



SYNAPSE MEDICAL BILLING

USER MANUAL

TASK LIST USER MANUAL



Task List – is a custom designed piece of software built by Synapse Medical Services to house Synapse workflows and processes.

- 1. LOG IN TO TASK LIST** - Synapse IT department will issue you with a log in for Task List.



Log In

Username

gjones

Password

.....


Log in

Forgotten your password?

Password not working?

Contact nervecentre@synapsemedical.com.au

- 2. YOU ARE NOW LOOKING AT THE TASK LIST 'HOME' SCREEN**


Task List
Clients ▾
Converting Task
Manual ▾
Logout

Filters
New Enquiry Task
New Arrear Task
New Form
New Task

Current tasks in queue

Task No.	Total	New	In Progress	1st QC	2nd QC	Final QC	Query	Claim Pending	Delay	Hold Claims	Synapse	OT Team	DP Team	Assigned to you
	1228	175	260	49	121	128	3	472	17	3	836	292	100	95

Date Filters
Start Date / / End Date / /

Task Type Filters
Task Type [Any status]

Status Filters
☐ Show All
 ☐ New
 ☐ In Progress
 ☐ 1st QC
 ☐ 2nd QC
 ☐ Final QC
 ☐ Completed and Sent
 ☐ Delayed
 ☐ Claims Pending
 ☐ Hold Claims
 ☐ Query
 ☐ Closed
 ☐ Deleted

Group/User Filters
Assigned To (Group) [Any group] Assigned To (User) [Any user]

Client Filters
Client [Any user]

Go

ID	Task Type	Client Name	Task Description	Status	Group	User	Start Date	Next Due	C'down	Days	BC Update
26782	IFC	Ratnapala, Mahilal	19/06 CABOOLTURE. Patient nam...	In Progress	Synapse	Asif Haideri	19/05/2015	21/05/2015		0	
26781	IFC	Ratnapala, Mahilal	22/05 CABOOLTURE. Patient nam...	In Progress	Synapse	Asif Haideri	19/05/2015	21/05/2015		0	
26780	REJECTION	Daily Rejection, Task		New	Synapse	Gabrielle Jones	19/05/2015	19/05/2015	111 min	0	
26779	RECEIPTING	Receipting, Task		New	Synapse	Gabrielle Jones	19/05/2015	19/05/2015	111 min	0	
26778	BILLING	Wei, James	St John Of God Bendigo	New	DP Team	-	19/05/2015	19/05/2015	111 min	0	
26777	BILLING	Warrier, Anita	North Shore Private	New	DP Team	-	19/05/2015	19/05/2015	111 min	0	
26776	BILLING	Thoo, William	North Shore Private Hospital	New	DP Team	-	19/05/2015	19/05/2015	111 min	0	

3. SYNAPSE PROCESSES CONDUCTED IN TASK LIST

Synapse uses the Task List software to create workflows for the following services we provide:

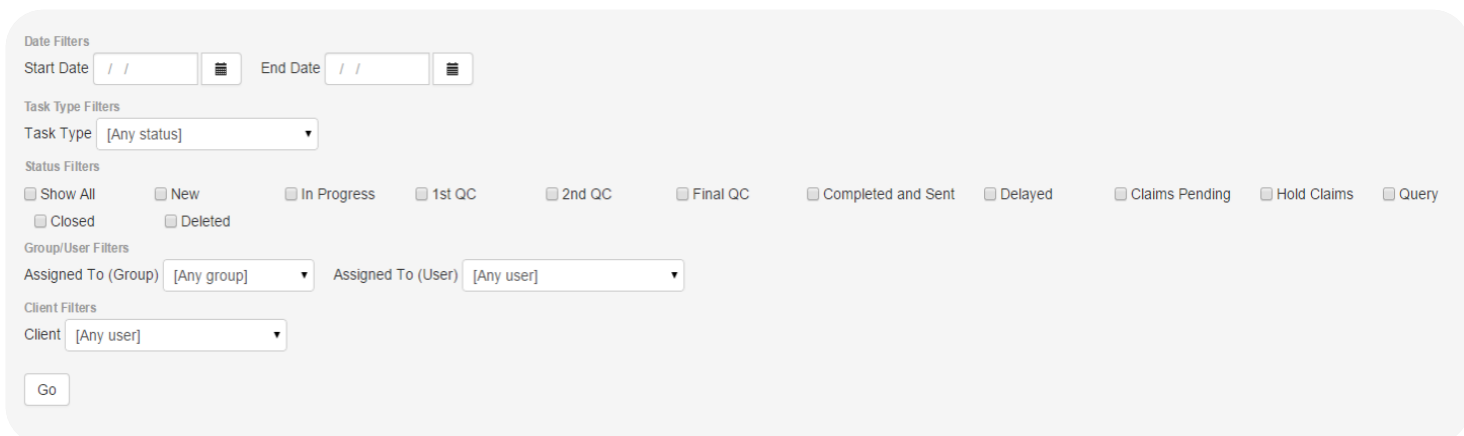
1. Medical Billing
2. Informed Financial Consent Service
3. Medical Transcription

Synapse also uses the Task List software for the following processes:

1. Daily Receipting
2. Daily Rejections
3. Registrations – New Client Sign Up
4. Enquires – Following up leads
5. Reporting

4. FILTERING TASK TYPES IN TASK LIST

The Task List software has a filter located at the top of every page.

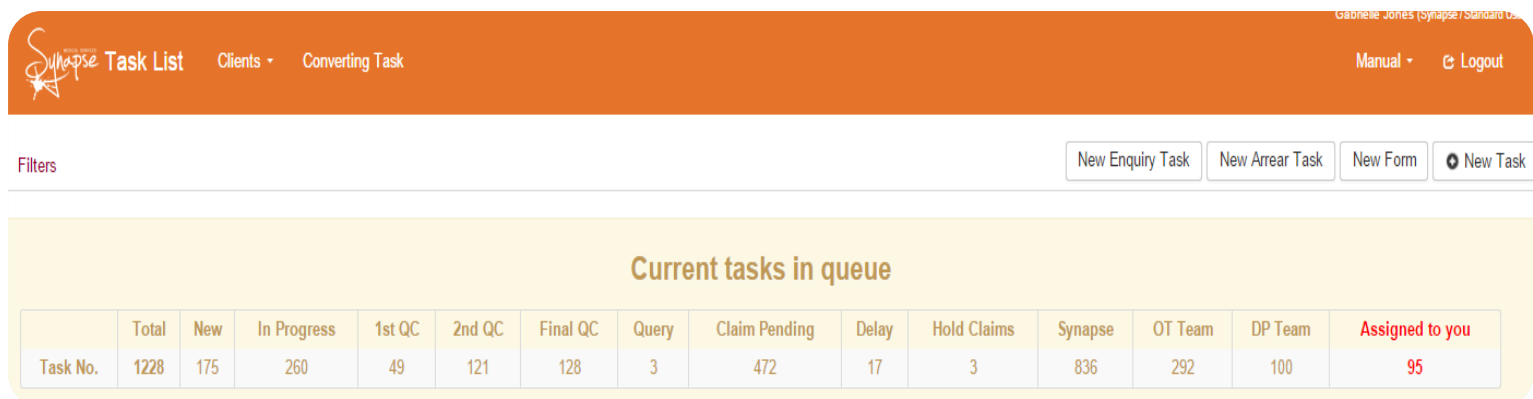


The screenshot shows the filter interface of the Task List software. It includes the following sections:

- Date Filters:** Start Date (/ /) and End Date (/ /) with calendar icons.
- Task Type Filters:** A dropdown menu labeled "Task Type" with the option "[Any status]".
- Status Filters:** A row of checkboxes for various task statuses: Show All, New, In Progress, 1st QC, 2nd QC, Final QC, Completed and Sent, Delayed, Claims Pending, Hold Claims, and Query. Below this row are checkboxes for Closed and Deleted.
- Group/User Filters:** Two dropdown menus: "Assigned To (Group)" with the option "[Any group]" and "Assigned To (User)" with the option "[Any user]".
- Client Filters:** A dropdown menu labeled "Client" with the option "[Any user]".
- Action:** A "Go" button at the bottom left.

1. **Task Type:** Allows you to change the range of tasks you are searching for. For example: Medical Billing tasks or Informed Financial Consent tasks.
2. **Status Filters:** Allows you to filter by the tasks
3. **Assigned to Group:** Allows users to filter tasks assigned to a specific team in the company or a specific individual.
4. **Client:** Filtering by a specific client can be very useful to find a specific task or to view the overall progress of all tasks for a client.

5. **TASK LIST QUEUE NOTIFICATION PANEL** – This panel allows you to view information about the amount of tasks currently in queue for processing and outlines how many tasks are in each process filter and any current tasks that are assigned to you.



The screenshot shows the Synapse Task List interface. At the top, there's a navigation bar with 'Task List', 'Clients', and 'Converting Task'. On the right, there are links for 'Manual' and 'Logout'. Below the navigation bar, there's a 'Filters' section and buttons for 'New Enquiry Task', 'New Arrear Task', 'New Form', and 'New Task'. The main section is titled 'Current tasks in queue' and contains a table with the following data:

	Total	New	In Progress	1st QC	2nd QC	Final QC	Query	Claim Pending	Delay	Hold Claims	Synapse	OT Team	DP Team	Assigned to you
Task No.	1228	175	260	49	121	128	3	472	17	3	836	292	100	95

6. SYNAPSE MEDICAL SERVICES TEAMS

DP TEAM

- **DATA PROCESSING TEAM (DP TEAM)**
- The data processing team initiate the billing process in all tasks and conduct the first quality control check.

OT TEAM

- **OPERATIONS TEAM (OT TEAM)**
- The operations team initiate all complex claiming, and conduct the second quality control check of all billing batches. They also follow up all arrears and operate the Synapse Saver Program.

SYNAPSE

- **SYNAPSE TEAM (SYDNEY & MELBOURNE)**
- The Synapse team conduct all final quality checks and answer any queries from the other teams and consult directly with the clients (Doctors).

TASK LIST WORKFLOW AND PROCEDURES - FILTERS

1. NEW

Billing drops into Task List via the “Synapps” smartphone app and the website, creating a NEW TASK and is assigned a TASK Number. Patients/Claim counts are automatically defined by “Synapps” generated tasks.

Steps for “NEW” tasks:

- DP Team complete picture conversion of the task and save task
- OT Team manually upload faxed billing.
- OT Team manually count and detail the amount of patients/claims for website and faxed billing.
- OT Team assign the task to the APPROPRIATE TEAM (Teams defined by Synapse, per doctor)

2. IN PROGRESS

Only ONE person needs to handle “In Progress” billing, this person is referred to as “Biller One”.

Biller one needs to:



- Mark the task as in progress

Using the Synapse Medical Service Billing instructions manual & the doctors billing sheet:

- Complete the billing of all patients (in the order that they appear on the page)
- If you are not sure how to bill a patient or need more information, complete the other patients and move the task to “1st QC”
- Check your billing to ensure there are no errors – Using a day sheet
- Mark the task as 1st QC, or to another process if 1st QC is not applicable

3. QUERY

Tasks are marked “In Query” if the task cannot be processed as a major piece of the information is incorrect and is needed to bill the majority of the claims in the task (See STEPS below).

4. HOLD

Tasks are marked “On Hold” if the task is unable to be processed as the doctor is not yet registered with the MAJOR health funds. Claims may also be placed on hold if there is an outstanding billing complication that is disrupting all of the doctors billing (See STEPS below).

5. STEPS FOR MARKING A TASK AS “IN QUERY” OR “ON HOLD”:

- Biller One - After realising during “IN PROGRESS” that you cannot bill the claims in this task, notify your supervisor of the issue with the batch
- Supervisor – Will determine if the task does require more information or whether the doctor is still pending registration, and will give Biller One permission to mark the task as “IN QUERY” or “ON HOLD”
- Biller One – Mark the task as “IN QUERY” or “ON HOLD”
- Supervisor – Email Billing Manager (Synapse) of the issue and task number (Query Tasks) or inform the registration team to send notification once the major funds have been registered

6. 1st QC – 1st QUALITY CONTROL CHECK

Only ONE person needs to handle billing in “1st QC”, this person is referred to as “Biller Two”

Biller two needs to:

- Print a day sheet and cross check all of the patient demographic data entry with the doctors billing sheet.
- Open the patient screen and verify the patient
- Using the day sheet and billing information, check that all patients have been billed correctly
- Once all details have been cross-checked, assign the task to “2nd QC”



7. 2nd QC – 2nd QUALITY CONTROL CHECK

Only ONE person needs to complete the 2nd Quality Control check, this person is referred as “Biller Three”.

Biller three needs to:

- Print a day sheet and cross check all of the patient demographic data entry with the doctors billing sheet
- Open the patient screen and verify the patient
- Ensure the patients title is labelled correctly: eg. Mr, Mrs, Miss Etc
- Using the day sheet and billing information, check that all patients have been billed correctly, double checking the billing type and fund fee
- Make NECESSARY calls to complete any billing for patients that were unable to be billed in the previous stages.
- Once all details have been cross-checked, assign the task to “Final QC”.

8. FINAL QC – FINAL QUALITY CONTROL CHECK

Only ONE person needs to complete the final checking of the batch, this person is referred as “Biller Four” and will be the fourth pair of eyes to view the batch.

Biller four needs to:

- Print a day sheet and use the doctors billing information sheet to cross check all of the patients billed and ensure that they have been billed correctly
- Make necessary calls or email to complete any outstanding billing for patients that were unable to be billed in the previous stages
- Assign all billed patients in the “Batch Handler”
- If there are un-billed patients, ASSIGN ALL OF THE BILLED PATIENTS and then move the task to “Claims Pending”
- Post any “Paper Claims” after all billing has been checked over
- If all patients have been successfully billed and assigned/posted, move the complete task to “Completed and Sent”



9. COMPLETED AND SENT

Once a task has been moved to “Completed and Sent”, every patient in the task has been billed and processed and assigned or sent via paper billing methods. Tasks can only enter “Completed and Sent” after a senior staff member has moved the batch from “Final Qc”. Tasks cannot be altered after they have been moved into “Completed and Sent”.

10. CLAIMS PENDING

Tasks become “Claims Pending” tasks after they have passed through “Final Qc” and are unable to be moved to “Completed and Sent”. Tasks are marked to “Claims Pending” by BILLER FOUR only, after all steps of “Final Qc” have been completed.

11. CLOSED

Tasks move into the “Closed” status after they have passed through “Completed and Sent” and have been marked off (CLOSED) on the website. This process allows the client to view the progress of their batch of billing.

12. DELAYED

Tasks in the “Delayed” status are tasks that are unable to be processed for a specific reason at the time of billing. The reason may occur as a result of a technical issue or an issue with a client’s provider numbers that is inhibiting their registration with Medicare/ the funds, or something else. These issues will be dealt with by the Sydney office by liaising with the client. Once the issue has been dealt with the task will be assigned to NEW and will continue through the task statuses.

SYNAPSE 5 DAY BILLING TURN AROUND TIME

5 DAY TURNAROUND – Synapse has a 5 business day turn-around-time (TAT's) for all medical billing tasks submitted by our clients.

HINT: Determining the 5 business day TAT's -If a batch of billing arrives before the 5pm cut off on any day – FOR EXAMPLE: Monday – they will be processed by the following Monday. If a batch arrives at 5.01pm or thereafter, the claims will be processed by Tuesday the following week.

5 DAY TURN AROUND – DAILY WORKFLOW

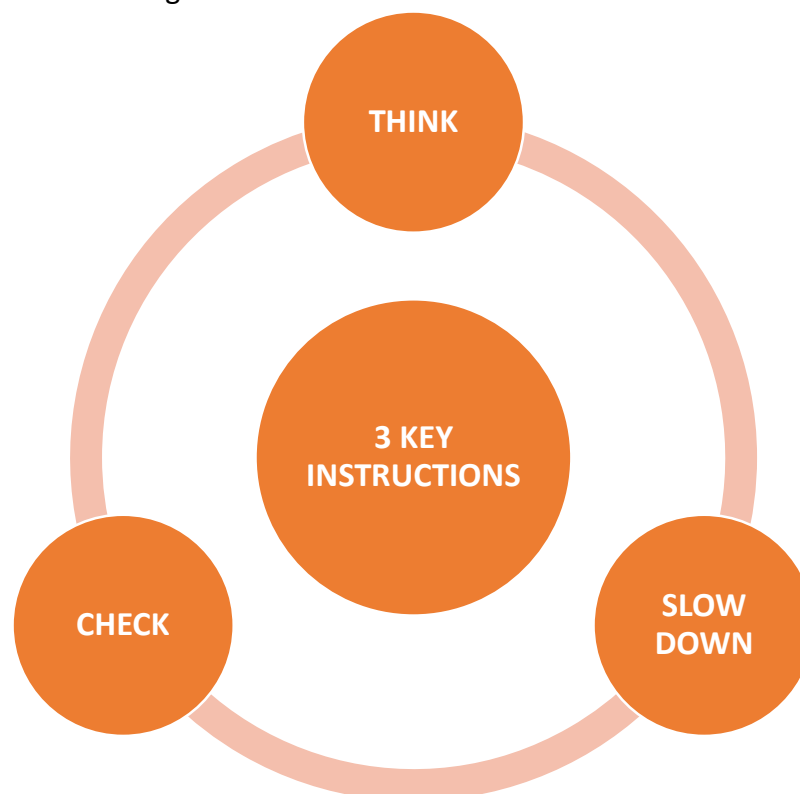
	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
TASKLIST STATUS	NEW QUERY HOLD IN PROGRESS	IN PROGRESS QUERY HOLD	1 st QC	2 nd Qc	FINAL QC COMPLETED & SENT CLAIMS PENDING CLOSED
STANDARD CLAIMS	DP TEAM	DP TEAM	DP TEAM	OT TEAM	OT TEAM SYNAPSE TEAM
COMPLEX CLAIMS	DP TEAM	OT TEAM	OT TEAM	OT TEAM	OT TEAM SYNAPSE TEAM
TASK ACTION	1. Picture Conversion 2. Data entry	1. Billing processing 2. Queries awaiting Synapse Confirmation 3. Awaiting Dr's registration	1. First quality check against day sheet 2. Complete errors	1. Second quality check against day sheet 2. Data chasing 3. Billing remaining patients	1. Final quality check against day sheet 2. Data chasing (from clients) 3. Completing billing 4. Assigning batches 5. Completing task 6. Closing task

PLEASE NOTE: BEING AHEAD OF SCHEDULE IS GREAT!

THINGS TO KNOW BEFORE YOU BILL

Medical billing – is the process of submitting and following up on claims, in order to receive payment for services rendered by a healthcare provider.

Synapse Medical Services takes pride in our knowledge and understanding of the complex operation of Australia's health care system. To ensure we are always billing correctly we follow 3 key instructions when completing any medical billing work.



THINK

1. Think before you bill

Think ahead, take time to focus on what you are billing and be clear about what type of billing you are using – before you start to bill.

Does it look right? Do the item numbers match the doctor chosen billing type? Does the IN or OUT Patient selection match the billing?

IMPORTANT THINGS TO REMEMBER: Doctors are busy and are usually in a hurry, they often make errors on their billing data. Doctors also don't know much about Medical Billing – That's what they hire us for. It is our job as their billing service provider to pick up on these errors and ensure that our clients are billing correctly. **IF SOMETHING DOESN'T LOOK RIGHT – LET YOUR SUPERVISOR KNOW BEFORE YOU BEGIN TO BILL THE CLAIMS**

SLOW DOWN

Take it SLOW – It's not a race

Rushing and trying to complete work quickly often leads to simple mistakes being made and attention to detail, forgotten. Taking it 'Slow' leads to increased productivity and less 'little' mistakes that can take a long time to fix.

Medical billing is very COMPLEX and requires precise ATTENTION TO DETAIL.

Follow these steps every time you bill to minimise mistakes:

1. Always have a printed copy of the doctors 'billing sheet' in front of you
2. Always check no changes have been made to the billing sheet – these notes will be written in the billing task.
3. Follow the "Synapse Medical Services Billing Manual" Instructions completely– Never guess.
4. Enter item numbers CAREFULLY and SLOWLY
5. Check every specific number entered on your screen matches the billing sheet.
6. Pay attention to detail and remember specific requirements of certain item numbers.
7. Proofread, edit and double check your work before passing the task on to the next stage.

CHECK

2. CHECK everything

Synapse Medical Services triple check all of our medical billing claims as we know how hard it is to correct a small mistake that has slipped through the system. One small mistake can lead to the rejection of an entire claim that could be worth thousands of dollars (\$) to our client.

Synapse incorporates a work flow that includes 4 quality control checking points. However any mistakes that are undetected prior to the FINAL QC stage are marked as an 'error' in our system.

The 4 CHECKS system:

1. Check your own billing – As explained in the SLOWN DOWN steps
2. 1st Quality Control (QC) Check
3. 2nd Quality Control (QC) Check
4. Final Quality Control (QC) Check

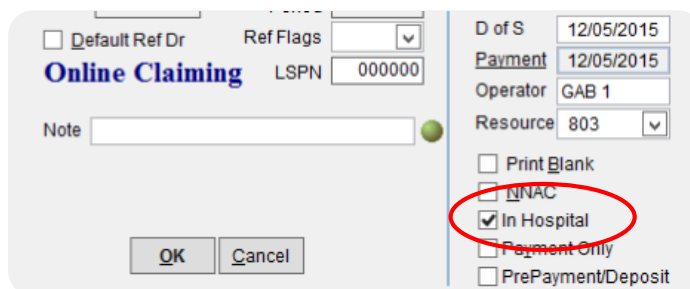
IN PATIENT VS OUT PATIENT



- You're an **INPATIENT** starting when you're formally admitted to a hospital. The day before you're discharged is your last inpatient day.
- You're an **OUTPATIENT** if you are treated by a doctor and you have not been admitted to a hospital. You can be treated at the emergency department of a hospital and still be an OUTPATIENT.

'In Patient' Claiming:

The billing process as outlined in the Synapse Medical Billing Manual, requires you to select the tick box "IN HOSPITAL" for all IN PATIENT services.



IMPORTANT INFORMATION: This step is the most critical step in the billing process.

THIS BOX MUST NOT BE TICKED FOR OUTPATIENT CLAIMS

Before TICKING the IN HOSPITAL BOX for ANY CLAIM:

- Take a moment to double check the doctors billing sheet to ensure they have selected INPATIENT or OUTPATIENT service
- Check the doctors billing type – If the billing type and service type do not match, inform your team leader to confirm that you can continue to bill the claim in the correct way.

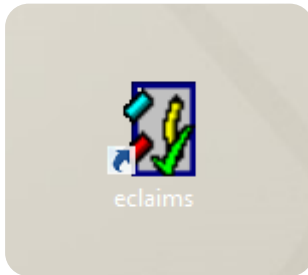
EXAMPLE: If the doctor has selected NO GAP as his billing type and OUT PATIENT as the service type then he has made an error and his billing should actually be IN PATIENT billing.

MEDICAL BILLING MANUAL – HOW TO BILL BASIC CLAIMS

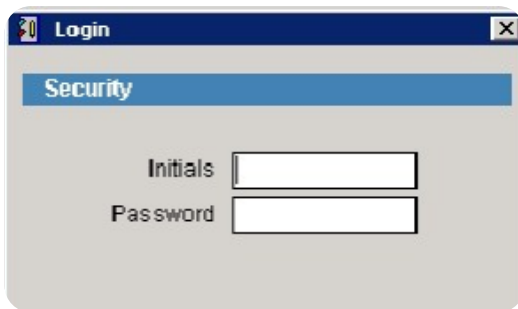
Synapse Medical Services utilises 'eclaims' software to conduct all medical billing process.

1. LOGIN TO ECLAIMS

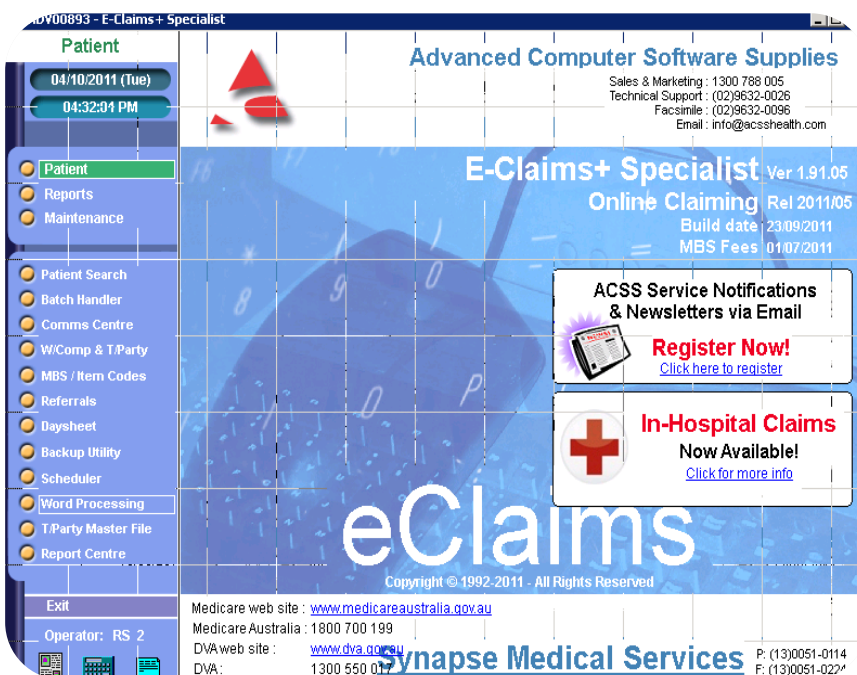
1. Click on the eclaims icon on your desktop to open program.



2. Use a valid user name and password and enter in the 'login' box (see below).

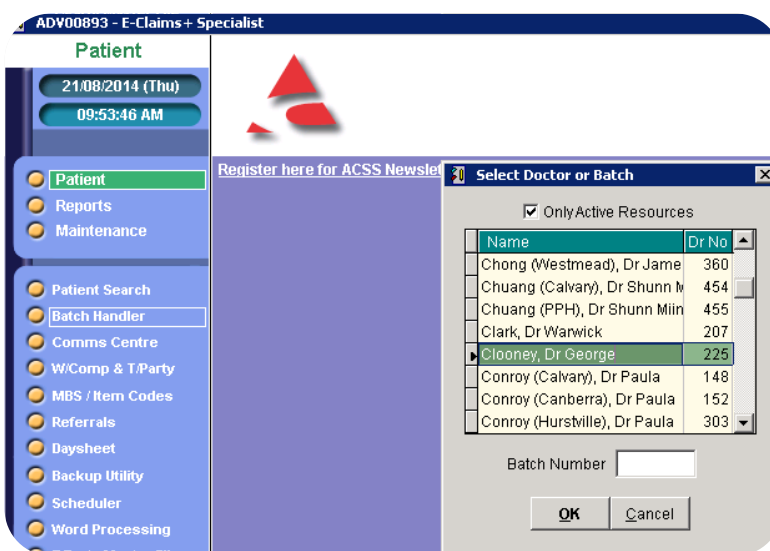


3. The eclaims home screen will open.



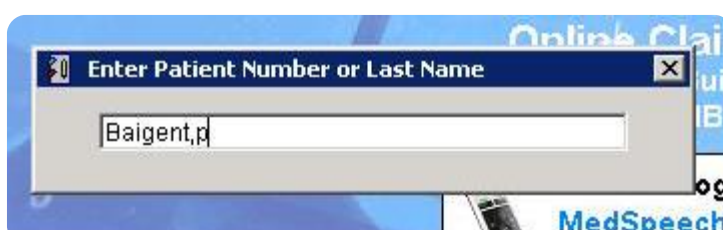
2. BEFORE YOU BEGIN TO PROCESS A CLAIM:

1. Review the claiming information that the doctor has provided to Synapse
2. Ensure the doctors 'Dr number (Dr No)' is in eclaims before starting to process the claim
 - a. Select Batch Handler
 - b. Scroll down the Batch Handler pop up box until you find the doctor
 - c. Find the correct 'Dr no' for the location provider number being claimed if there is more than one listing for the doctor in the batch handler
 - d. Note the doctors number on the right hand side of the box

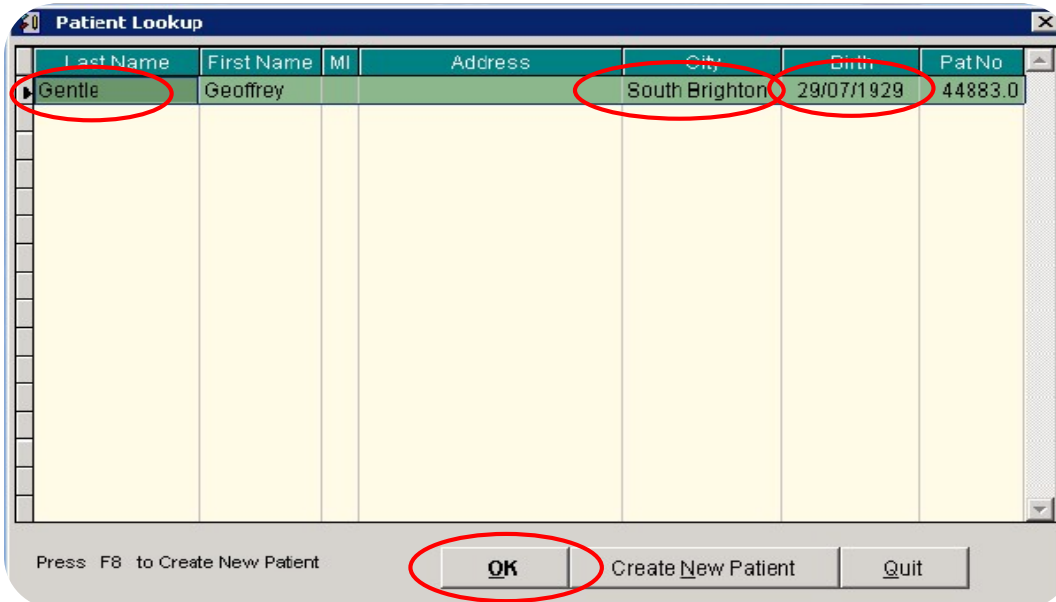


3. SEARCHING FOR A PATIENT

1. Click on 'Patient Search' Button on the left side of the screen
 2. Search for the patient using a method bellow:
 - a. Enter patient's last name, first name – or last name, initial (eg. Smith, M)
- For previously created patients:
- b. Enter patient number
 - c. Enter patients date of birth (DOB) in the following format DD/MM/YYYY (eg. 01/01/1988)



3. 'Patient lookup' box will appear - *See Image Below*
4. Select the correct patient
5. Cross check the DOB & Address suburb (city field)
6. Click OK



Last Name	First Name	MI	Address	City	Birth	Pat No
Gentle	Geoffrey			South Brighton	29/07/1929	44883.0

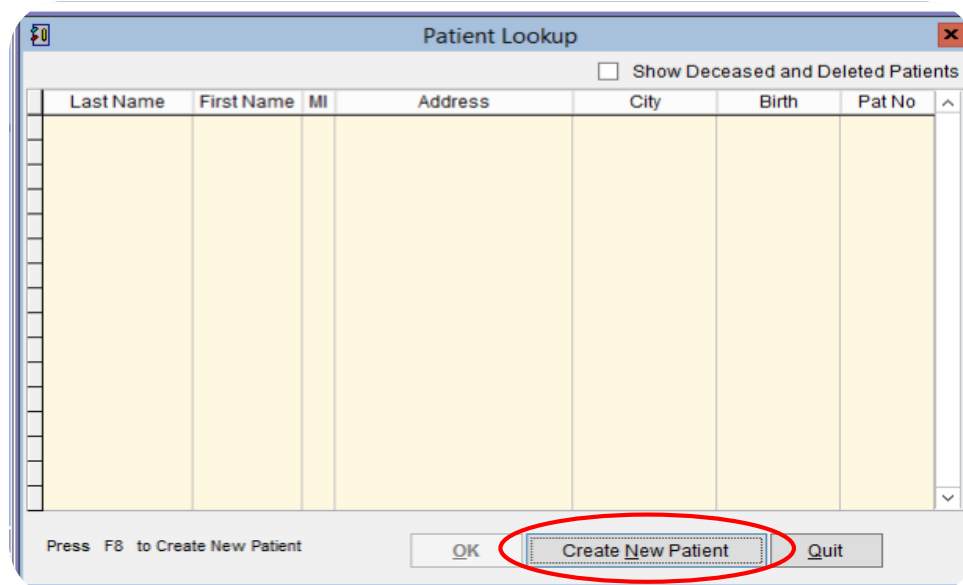
Press F8 to Create New Patient

OK Create New Patient Quit

- **ONLY PROCEED TO BILLING PROCESS STEP 4** where all details given on the screen matches the patient's details given by the Doctor.
- **IF THE PATIENT DOES NOT APPEAR DURING PATIENT SEARCH CONTINUE TO STEP 4.**

4. CREATING A NEW PATIENT:

- Only create a new patient if the search for a patient shows the patient is not in the eclaims system.

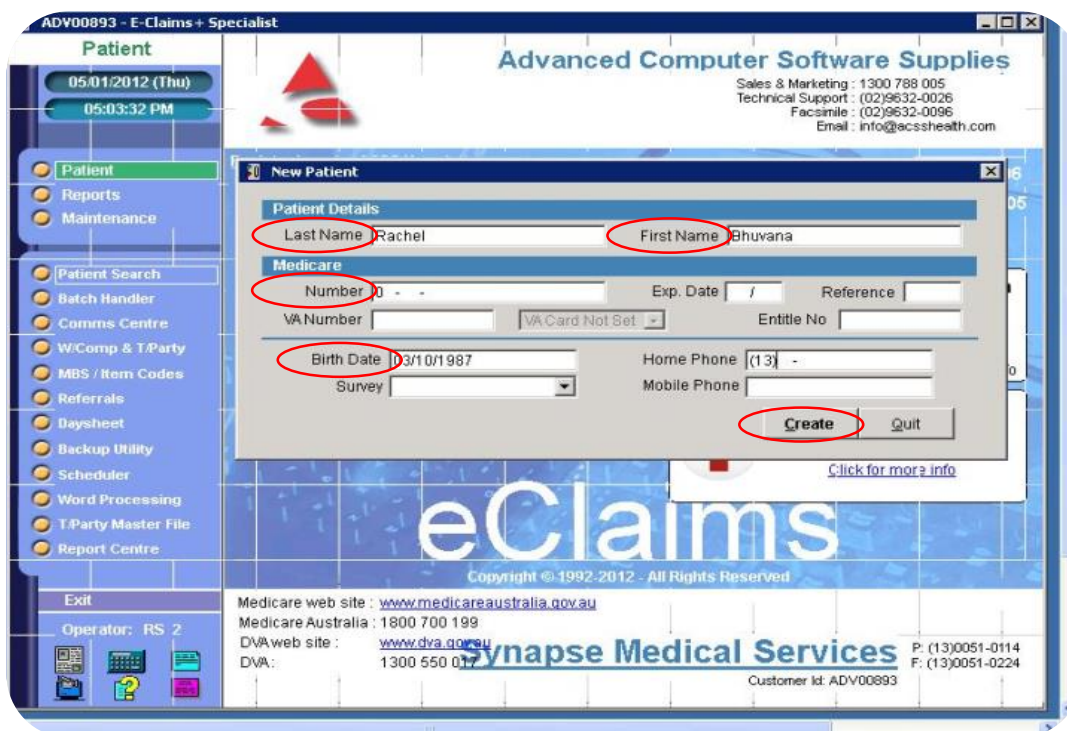


Last Name	First Name	MI	Address	City	Birth	Pat No
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Press F8 to Create New Patient

OK Create New Patient Quit

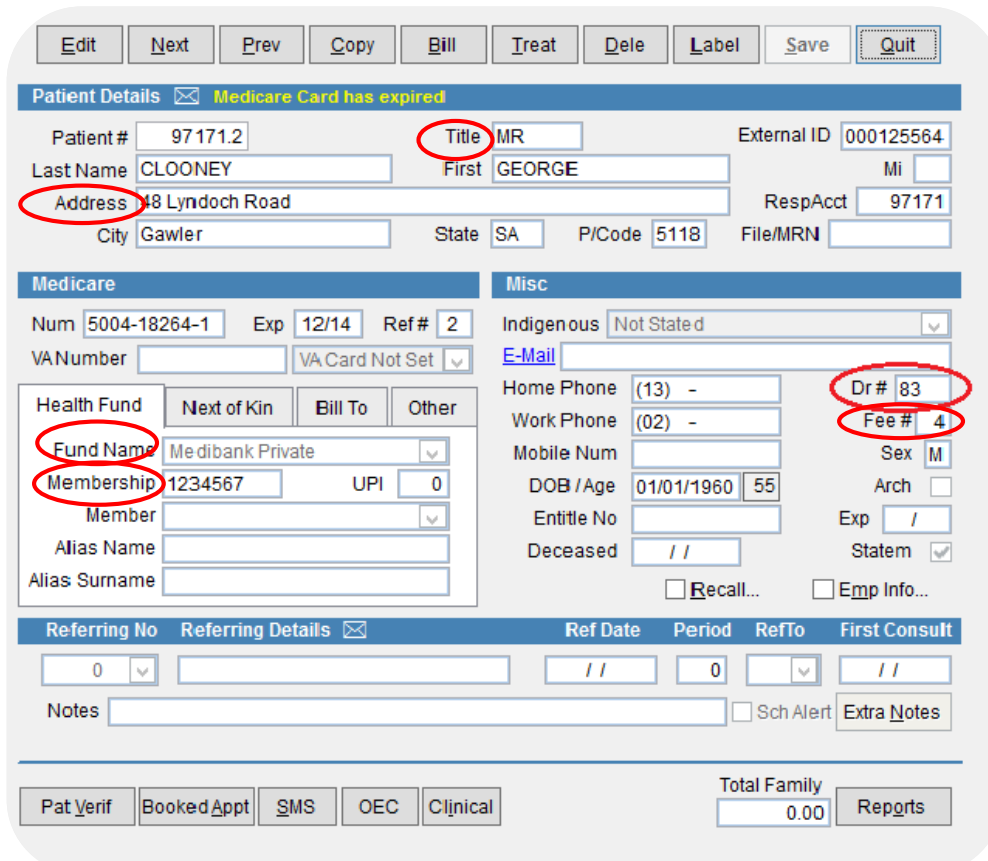
1. Click 'Create New Patient'
2. 'New Patient' screen appears – *See below image*
3. Enter the patient first & last name
4. Enter the patients Medicare and / or veterans affairs (DVA) details:
 - a. Enter Medicare number
 - b. Enter Medicare expiry date if it is provided. If it is not provided use a default of 12/12/YYYY (where YYYY = this year)
 - c. Enter Medicare reference number if it is provided. If it is not use a default of 1=male; 2=female; 3 or higher number= child
 - d. Enter veterans affairs number (If the Veterans number is not provided enter the number as #NX123456)
5. Enter patients DOB
6. Select "Create"



The screenshot displays the 'New Patient' form within the eClaims software interface. The form is titled 'New Patient' and contains several sections: 'Patient Details' with fields for 'Last Name' (filled with 'Rachel') and 'First Name' (filled with 'Bhuvana'); 'Medicare' section with fields for 'Number', 'Exp. Date', 'Reference', 'VA Number', and 'Entitle No'; and a 'Birth Date' field (filled with '03/10/1987'). There are also fields for 'Home Phone' and 'Mobile Phone'. A 'Create' button is located at the bottom right of the form, circled in red. The background of the software window shows the 'eClaims' logo, copyright information (©1992-2012), and contact details for Synapse Medical Services, including Medicare and DVA web sites and phone numbers.

7. 'Patient Screen' box will appear – *See image below*
 - *Patient data entered already will auto-populate into the 'new patient' box.*
8. Enter remaining patient demographic information into the fields provided
 - a. Enter title
 - *Correct Gender must be selected – (see Doctors billing sheet for patients gender)*

- b. Enter address
- *If patients location details are not available use the city, state and postcode of the hospital where the services were provided as per the billing sheet of the doctor*
- c. Enter Medicare expiry date if it is provided.
- *If it is not provided use a default of 12/12/YYYY (where YYYY = this year)*



The screenshot shows a patient entry form with the following sections and fields:

- Buttons:** Edit, Next, Prev, Copy, Bill, Treat, Dele, Label, Save, Quit.
- Patient Details:**
 - Patient # 97171.2, Title MR, External ID 000125564
 - Last Name CLOONEY, First GEORGE, Mi
 - Address 48 Lyndoch Road, City Gawler, State SA, P/Code 5118, File/MRN
 - RespAcct 97171
- Medicare:**
 - Num 5004-18264-1, Exp 12/14, Ref # 2
 - VA Number, VA Card Not Set
 - Health Fund: Fund Name Medibank Private, Membership 1234567, UPI 0
 - Member, Alias Name, Alias Surname
- Misc:**
 - Indigenous Not Stated, E-Mail
 - Home Phone (13) -, Work Phone (02) -, Mobile Num
 - DOB / Age 01/01/1960 55, Entitle No, Deceased //
 - Sex M, Arch, Exp /, Statem
 - Dr # 83, Fee # 4
 - Recall..., Emp Info...
- Referring No Referring Details:**
 - Ref No 0, Ref Date //, Period 0, RefTo, First Consult //
 - Notes, Sch Alert, Extra Notes
- Buttons:** Pat Verif, Booked Appt, SMS, OEC, Clinical
- Total Family:** 0.00, Reports

9. Enter the correct Doctor number (Dr #) (see: PAGE 2 for instructions)
10. Enter the correct Fee Number
 - a. Use the “Eclaims Fund Numbers List” table below to determine the fee number
 - b. Locate the patients’ health fund (take caution to select the correct STATE)
 - c. Write the number beside the fund’s name in the FEE NUMBER box in the patient screen.

Eclairs Health fund billing Fee numbers list

Number	Fund	Type
0	Veterans and Medicare bulk bill	Electronic
1	Medicare schedule fee (Simona Balan business hours)	Paper
2	Workers comp (AMA rates)	Paper
3	Workcover VIC (TAC)	Eclipse Scheme
4	Medibank Private and AHM	Eclipse Scheme
5	HCF	Eclipse agmt
6	NIB	Eclipse Scheme
7	BUPA QLD	Eclipse agmt
8	AHSA NSW	Eclipse Scheme
9	BUPA NSW	Eclipse agmt
10	GMHBA and (all funds 20% above schedule fee)	Eclipse agmt
11	BUPA SA	Eclipse agmt
12	BUPA VIC	Eclipse agmt
13	Latrobe and (all funds 25% above schedule fee)	Eclipse agmt
14	Workcover QLD	Paper
15	AHSA VIC	Eclipse Scheme
16	AHSA SA	Eclipse Scheme
17	AHSA QLD	Eclipse Scheme
18	St Lukes Health	Eclipse agmt
19	BUPA Tasmania	Eclipse agmt
20	AHSA Tasmania	Eclipse Scheme
21	BUPA WA	Eclipse agmt
22	AHSA WA	Eclipse Scheme
23	HBF	Eclipse agmt
25	Balan AH (Simona Balan after hours) 120% schedule fee	Paper to hospital
29	AMA \$45 / Unit (Mark Porter)	?Paper
30	80% of AMA rates (Warwick Clark at Manly Hospital)	Complex claim
DVA - ih	DVA In Hospital (only)	?

HINT: Find the AHSA & BUPA State Fee Numbers listed on the table below:

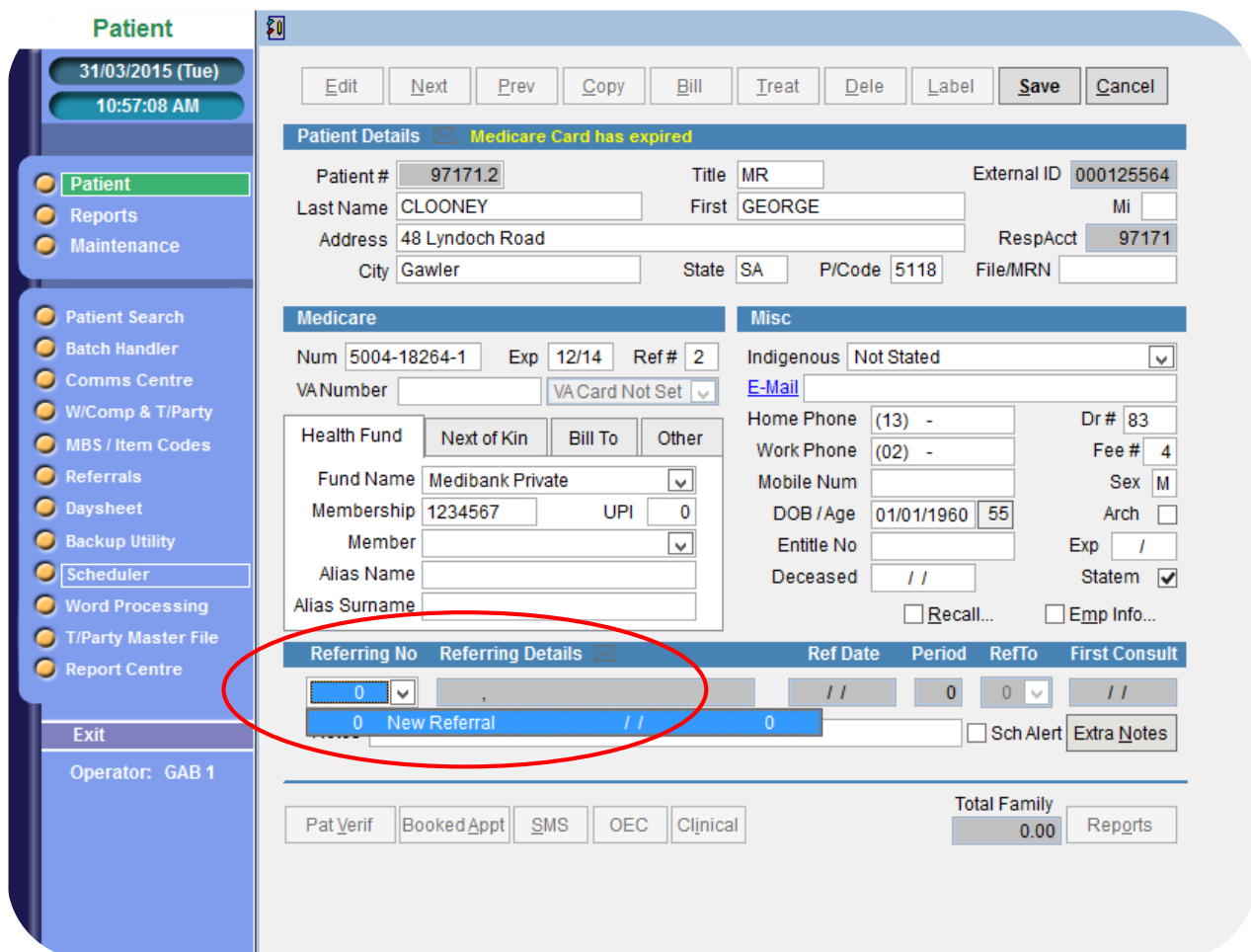
NSW Doctors	AHSA fee# 8 & BUPA fee# 9
VIC Doctors	AHSA fee# 15 & BUPA fee# 12
SA Doctors	AHSA fee #16 & BUPA fee#11
ACT Doctors	AHSA fee# TBA and BUPA fee# TBA
QLD Doctors	AHSA fee# 17 & BUPA fee# 7

11. Enter the correct Health fund Name
12. Enter membership number
13. If Veterans – Enter Veterans number

HINT: Billing Veterans Patients – If patient verifies with Veterans – Bill in the following way:

- a. Veterans Gold Card only – Bill using Veterans Gold Card
- b. Veterans Gold Card & Health fund details (Bill using Veterans Gold Card
- c. Veterans White Card only – Bill using veterans white card
- d. Veterans White Card & Health Fund details – Bill to patients Health Fund

14. Enter the referring doctor details



- a. Look up referring doctor in the eclaims 'Referral' List and select correct doctor
- Search using: Last name, Provider no or location (City)
- b. If referring doctor is not in the list – Select 'NEW' and create a new referring doctor
- Note referral date rules- Specialist referral lasts 3 months. GP referral lasts 12 months.

HINT: Referring Doctor – Helpful Information

- No referring doctor needed for anaesthetics claims
- If not able to identify the correct referral details then check to see if the patient had had a previous referring doctor. You may use an EXISTING REFERRAL IF THE REFERRAL DOCTOR IS LOCATED IN A SIMILAR LOCATION TO THE PLACE WHERE THE PATIENT RECEIVED TREATMENT.
- If not able to enter correct referral details contact the Synapse billing manager

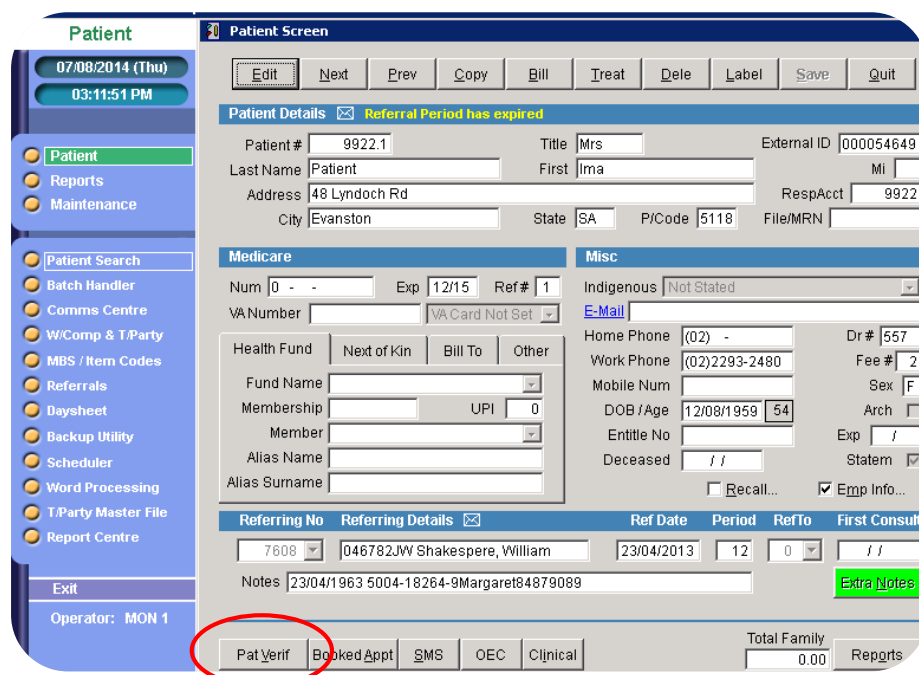
15. Enter referral date

- Enter the correct referral date details as per the claiming details provided by the doctor.
- If NO DATE is given use the default – 1 day prior to the Date of Service (DOS)

5. VERIFYING PATIENTS DETAILS:

Verifying a patient is MANDATORY before commencing the rest of the billing task. Verifying a patient is a critical and an essential quality step in the billing process. Verifying patient details confirms that the patient is eligible for Medicare or health fund claims.

- Ensure the correct patient has been selected
- OR
- All details have been entered for a new patient
- Verify patient by pressing 'Pat Verify'



Patient Screen

07/08/2014 (Thu) 03:11:51 PM

Patient Details Referral Period has expired

Patient # 9922.1 Title Mrs External ID 000054649
 Last Name Patient First Ima MI
 Address 48 Lyndoch Rd RespAcct 9922
 City Evanston State SA P/Code 5118 File/MRN

Medicare **Misc**

Num 0 - - Exp 12/15 Ref # 1 Indigenous Not Stated
 VA Number VA Card Not Set E-Mail
 Health Fund Next of Kin Bill To Other Home Phone (02) - Dr # 557
 Fund Name Membership UPI 0 Work Phone (02)2293-2480 Fee # 2
 Member Mobile Num DOB / Age 12/08/1959 54 Sex F
 Alias Name Entitle No Exp / Arch
 Alias Surname Deceased / / StateM ☒ ☐ Recall... ☒ Emp Info...

Referring No **Referring Details** **Ref Date** **Period** **RefTo** **First Consult**

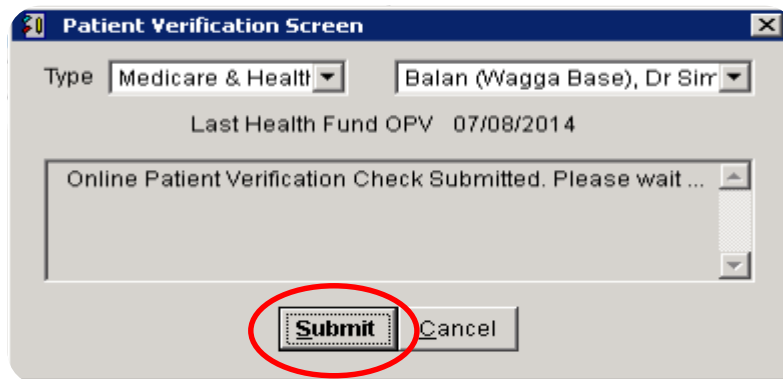
7608 046782JW Shakespeare, William 23/04/2013 12 0 / /

Notes 23/04/1963 5004-18264-9Margaret84879089 Extra Notes

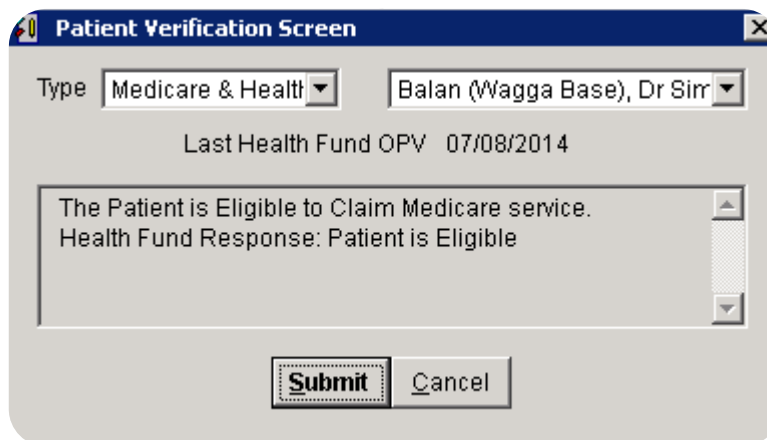
Operator: MON 1

Pat Verify **Booked Appt** **SMS** **OEC** **Clinical** **Total Family** 0.00 **Reports**

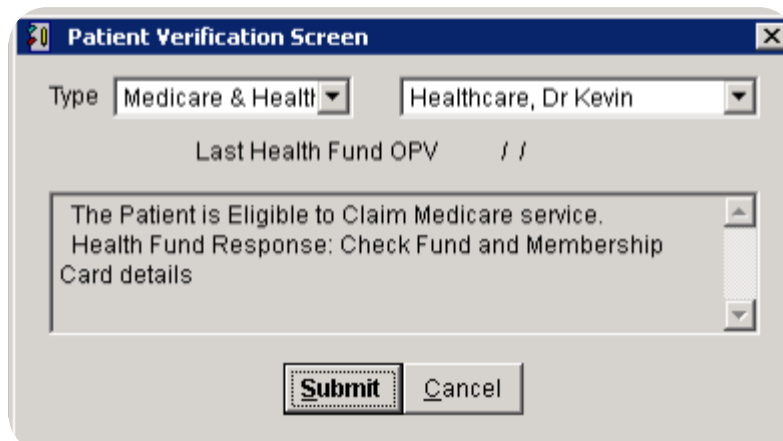
4. 'Patient Verification Screen' will appear
5. Select 'Submit'
6. Wait for eclaims to verify the patient details



7. Possible outcomes of patient verification:
 - a. Patient will verify for BOTH MEDICARE and FUND you will see a message

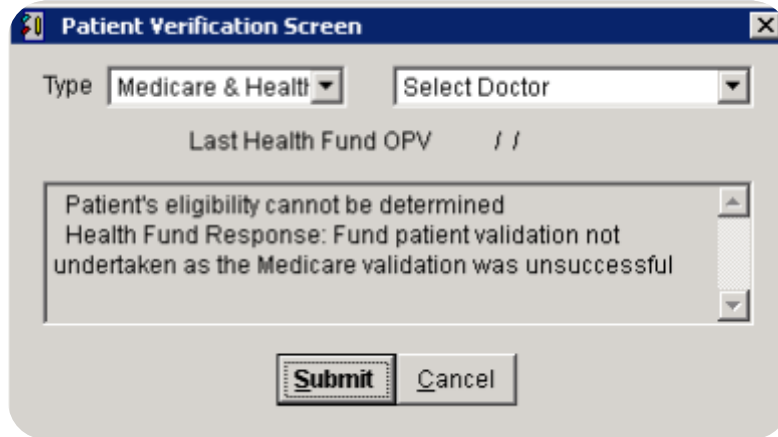


- b. Patient verifies for one OR other but not both



c. Patient DOES NOT verify at all.

- *If patient details cannot be determined – See instructions below under ‘if patient does not verify’*



Patient Verification Screen

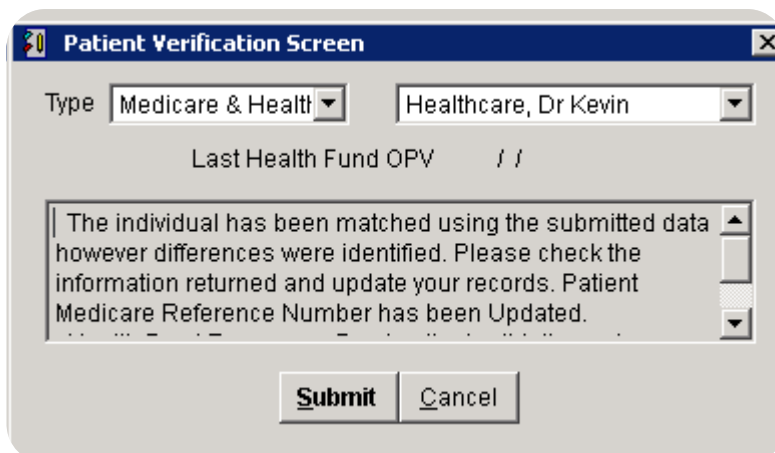
Type: Select Doctor:

Last Health Fund OPV: / /

Patient's eligibility cannot be determined
Health Fund Response: Fund patient validation not undertaken as the Medicare validation was unsuccessful

d. Patient is MATCHED with differences and could not verify.

- *If the below message is shown during patient verification – CLICK SUBMIT again (Medicare will update patient details where all other details match)*



Patient Verification Screen

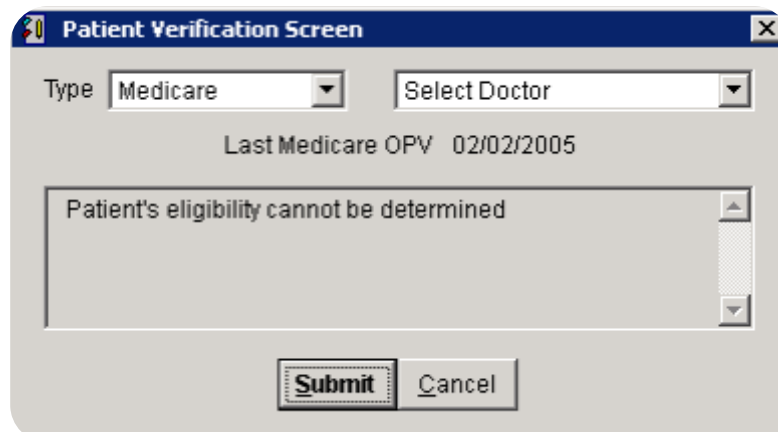
Type: Healthcare, Dr Kevin

Last Health Fund OPV: / /

The individual has been matched using the submitted data however differences were identified. Please check the information returned and update your records. Patient Medicare Reference Number has been Updated.

e. Patient's eligibility cannot be determined:

- *If the doctor is BULK BILLING claims and this message appears during verification - DO NOT BILL THE CLAIM and begin process for obtaining correct Medicare numbers.*



Patient Verification Screen

Type: Select Doctor:

Last Medicare OPV: 02/02/2005

Patient's eligibility cannot be determined

8. IF PATIENT DOES NOT VERIFY – Try the following methods:

1. Check that you have entered ALL details CORRECTLY – *then try the following options:*
 - a. Change the “Type” selection to suit the claim (Medicare, Health fund, Medicare and Health fund, Veterans) and retry verification
 - b. If the patient is female, change the Medicare reference number from 1 to 2 and try verifying the patient again
 - c. Change the last digit of the Medicare card (the issue number) up one number or down one number and try verifying the patient again
2. Ensure all combinations of steps above have been attempted
3. If none of the above options result in successful verification, check with your manager
4. APPROVED STAFF ONLY - contact the hospital (if not a Synapse client) for Medicare & health fund details, the health fund for health fund details or Medicare for Medicare numbers. If no calls result in the correct details being obtained mark in Final QC in Tasklist to Synapse Billing Manager.

HINT: Possible issues hindering PATIENT VERIFICATION:

- a. If the patient eligibility could not be determined (the patient may have died) the claim will need to be billed as a paper claim. Discuss this possibility with a manager.
- b. If a verification message “The patient is eligible to claim Veterans Service. Veteran Entitlement Code: Pensioner Concession Card” appears this means that the patient is not a full Veteran and cannot be billed as a Veteran. Bill using the patients Medicare and Health Fund details for a No Gap claim instead.

9. **BILLING THE MEDICAL CLAIM:**

Once all patient demographic details are correctly entered or found during a search in eclaims and have verified, the billing process may begin using the following steps:

The claim details can be entered using the claiming information provided by the doctor.

10. **TYPES OF BILLING**

There are six routine types of billing completed at Synapse:

1. **No gap**

No Gap claims are only INPATIENT claims. Never outpatient claims.

2. **Medicare (bulk billing)**

Either inpatient or outpatient

3. **Veterans affairs**

Either inpatient or outpatient

4. **Workers' Compensation**

Either inpatient or outpatient.

5. **Third Party**

Either inpatient or outpatient

6. **Patient Claims**

Either inpatient or outpatient

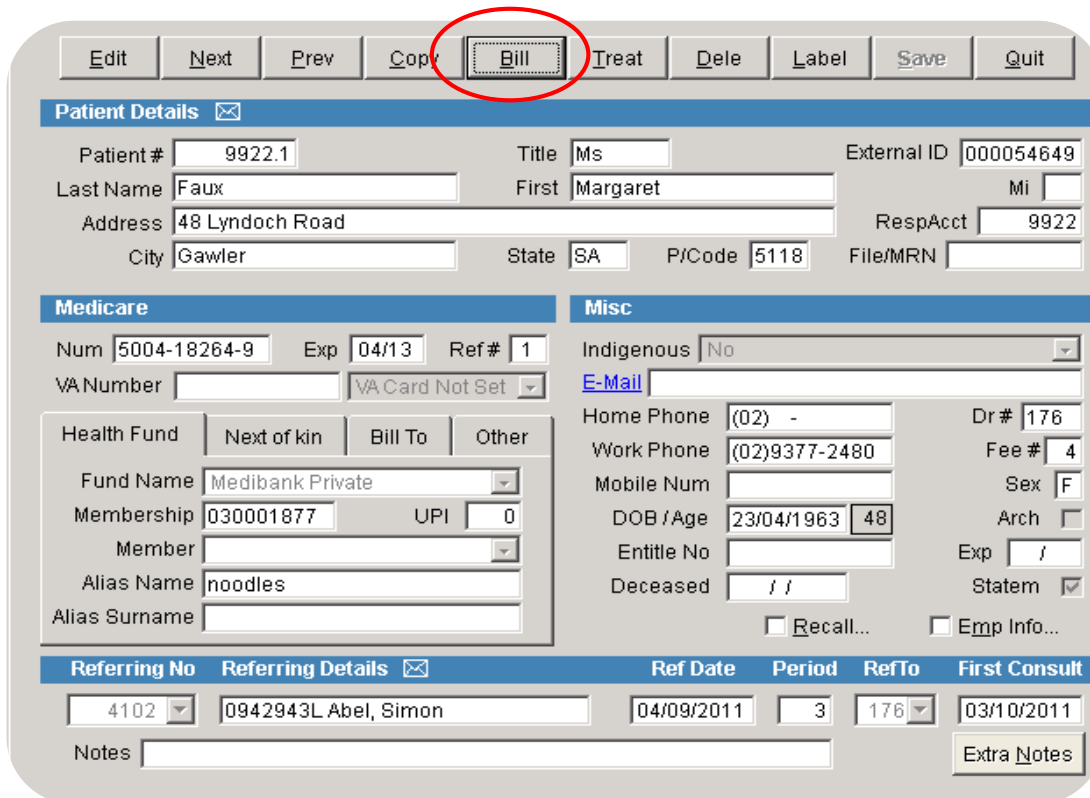
7. **Known gap**

Known Gap claims are only INPATIENT claims. Never outpatient claims.

11. **PROCESS FOR BILLING A CLAIM**

1. Select the "BILL" function button in the patient screen

The "Billing" box will appear. Each type of billing requires different input into the "Billing" box when it appears. The patient details and the doctor details that have been entered so far in the billing process will appear in the "Billing" box. Further details are required for all types of billing. Up to fourteen items can be routinely claimed on one invoice.



Toolbar: Edit, Next, Prev, Copy, **Bill** (circled), Treat, Dele, Label, Save, Quit

Patient Details

Patient # 9922.1 Title Ms External ID 000054649
 Last Name Faux First Margaret MI
 Address 48 Lyndoch Road RespAcct 9922
 City Gawler State SA P/Code 5118 File/MRN

Medicare

Num 5004-18264-9 Exp 04/13 Ref # 1
 VA Number VA Card Not Set

Misc

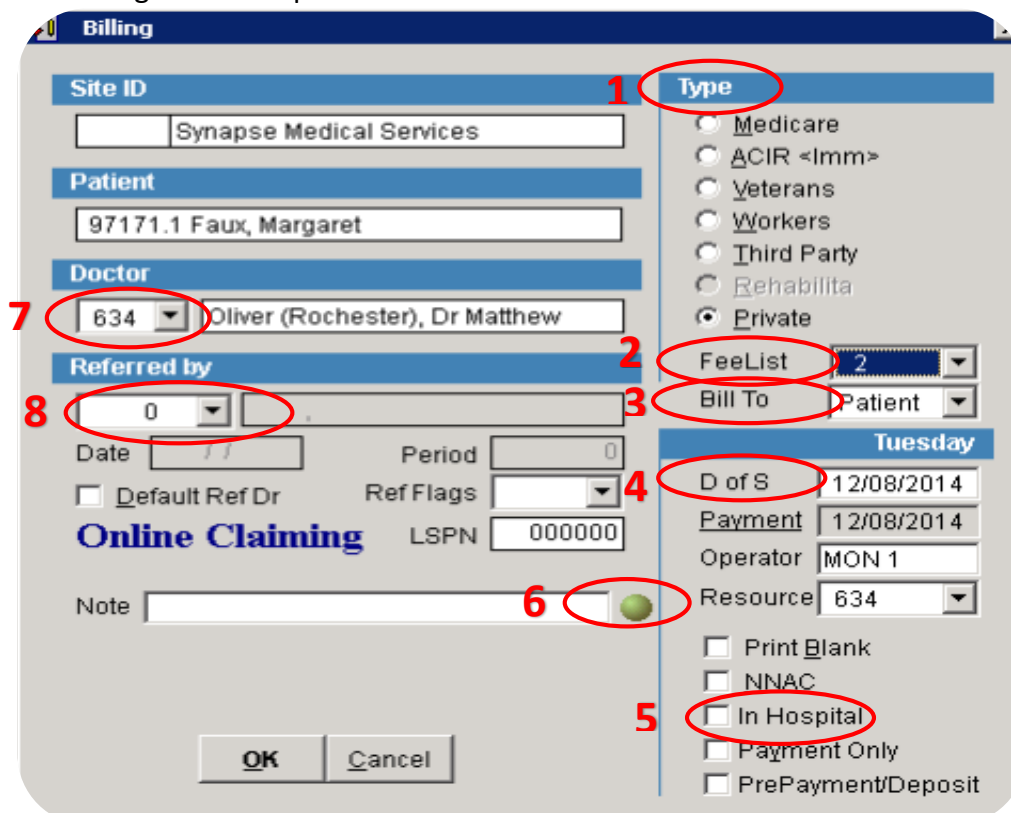
Indigenous No E-Mail
 Home Phone (02) - Dr # 176
 Work Phone (02)9377-2480 Fee # 4
 Mobile Num Sex F
 DOB / Age 23/04/1963 48 Arch
 Entitle No Exp /
 Deceased / / Statem
☐ Recall... ☐ Emp Info...

Referring No Referring Details Ref Date Period RefTo First Consult

4102 0942943L Abel, Simon 04/09/2011 3 176 03/10/2011

Notes Extra Notes

2. The "Billing box" will open



Billing

Site ID Synapse Medical Services **1** **Type**

Patient 97171.1 Faux, Margaret

Doctor **7** 634 Oliver (Rochester), Dr Matthew

Referred by **8** 0 **2** **FeeList** 2

3 **Bill To** Patient

4 **D of S** 12/08/2014

5 **In Hospital**

6 **Note**

Online Claiming LSPN 000000

Payment 12/08/2014

Operator MON 1

Resource 634

☐ Print Blank

☐ NNAC

☐ Payment Only

☐ PrePayment/Deposit

OK Cancel

3. For all types of billing:

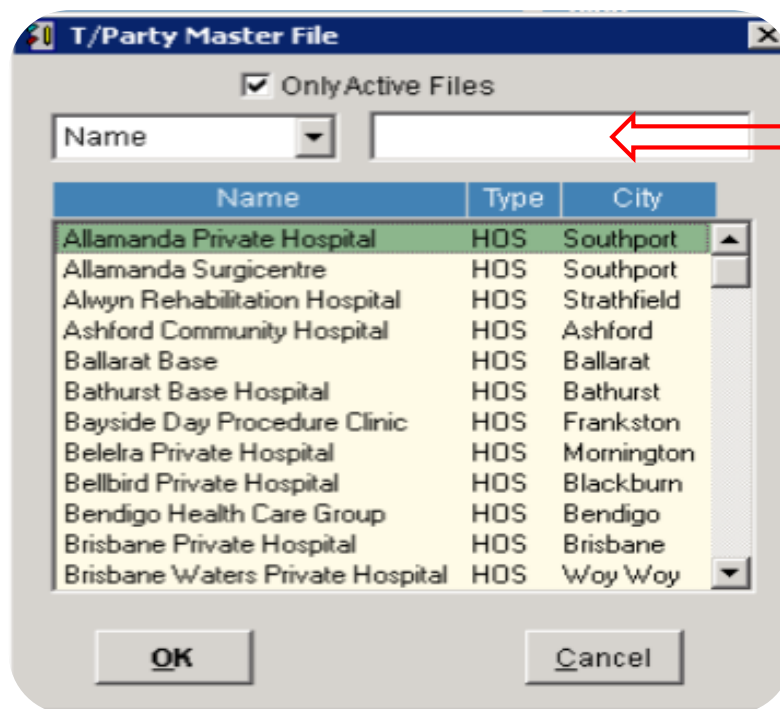
- Select correct "Type"
- Check correct Fee List appears

Number	Fund	Type
0	Veterans and Medicare bulk bill	Electronic
1	Medicare schedule fee (Simona Balan business hours)	Paper
2	Workers comp (AMA rates)	Paper
3	Workcover VIC (TAC)	Eclipse Scheme
4	Medibank Private and AHM	Eclipse Scheme
5	HCF	Eclipse agmt
6	NIB	Eclipse Scheme
7	BUPA QLD	Eclipse agmt
8	AHSA NSW	Eclipse Scheme
9	BUPA NSW	Eclipse agmt
10	GMHBA and (all funds 20% above schedule fee)	Eclipse agmt
11	BUPA SA	Eclipse agmt
12	BUPA VIC	Eclipse agmt
13	Latrobe and (all funds 25% above schedule fee)	Eclipse agmt
14	Workcover QLD	Paper
15	AHSA VIC	Eclipse Scheme
16	AHSA SA	Eclipse Scheme
17	AHSA QLD	Eclipse Scheme
18	St Lukes Health	Eclipse agmt
19	BUPA Tasmania	Eclipse agmt
20	AHSA Tasmania	Eclipse Scheme
21	BUPA WA	Eclipse agmt
22	AHSA WA	Eclipse Scheme
23	HBF	Eclipse agmt
25	Balan AH (Simona Balan after hours) 120% schedule fee	Paper to hospital
29	ANA \$45 / Unit (Mark Porter)	?Paper
30	80% of AMA rates (Warwick Clark at Manly Hospital)	Complex claim
DVA - ih	DVA In Hospital (only)	?

- c. Select correct “Bill To” option
- d. Enter Date of Service in “D of S” filed
- e. Select “In hospital” for all INPATIENTS

HINT: Ensure the tick box is NOT selected for “In Hospital” for all OUTPATIENTS

- f. Select Hospital if hospital required by:
 - a. Selecting the green ball button
 - b. Start typing the location of the treatment (hospital or clinic name)
 - c. Select correct location (hospital or clinic)



Name	Type	City
Allamanda Private Hospital	HOS	Southport
Allamanda Surgicentre	HOS	Southport
Alwyn Rehabilitation Hospital	HOS	Strathfield
Ashford Community Hospital	HOS	Ashford
Ballarat Base	HOS	Ballarat
Bathurst Base Hospital	HOS	Bathurst
Bayside Day Procedure Clinic	HOS	Frankston
Beleira Private Hospital	HOS	Mornington
Bellbird Private Hospital	HOS	Blackburn
Bendigo Health Care Group	HOS	Bendigo
Brisbane Private Hospital	HOS	Brisbane
Brisbane Waters Private Hospital	HOS	Woy Woy

Search Hospital Name

- g. Select referring doctor in "Referred by" field if required
- h. Select referral date "Referred by" field if required
- i. Select OK only once all correct details are entered and checked

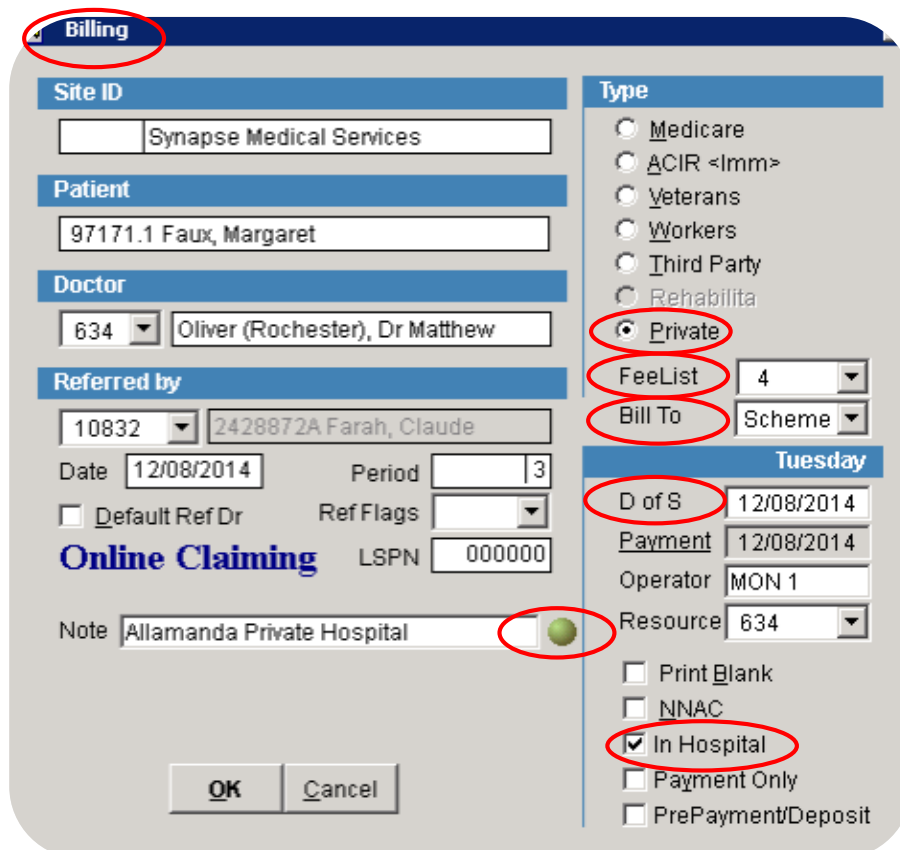
GENERAL BILLING HINTS:

1. Where possible when a batch includes claims for items on different dates of service, bill in one invoice.
2. To process for claims with more than 14 items:
 - a. Contact the fund
 - b. Request guidance on how to lodge the claim
 - c. Suggest splitting over two invoices and gain a reference number and / or a contact person to follow the claim through to its completion
 - d. Fax the claim directly to the contact person (include the reference number when provided with one)
 - e. Follow the progress of the claim regularly
 - f. Enter notes in eclaims after each contact with the fund

BILLING A CLAIM FOR EACH CLAIM TYPE WILL NOW BE SHOWN

1. NO GAP BILLING

1. Select the "BILL" function button in the patient screen
2. The "Billing" box will appear.
3. Check details that appear in eclaims with the billing information provided by the doctor

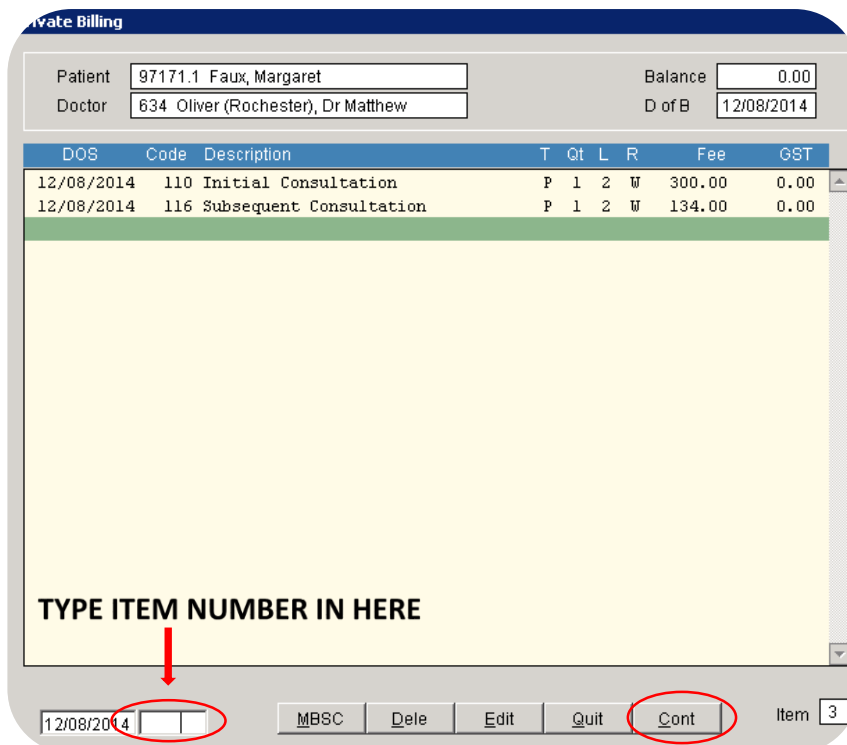


REPEAT ALL STEPS SHOWN IN PAGES 25-27

4. Select "Private" for billing "Type"
5. Check correct FeeList appears (see fee list table above)
6. Check correct "Bill To" field appears and if not change (see fee list table above)
7. Enter Date of Service in "D of S" field
8. Select "In hospital" for all INPATIENTS
9. Ensure the tick box is NOT selected for "In Hospital" for all OUTPATIENTS
10. Select Hospital if required (shown on page 26-27)
11. Select referring doctor and referral date in "Referred by" field if (shown on page 19-20)
12. Select OK only once all correct details are entered and checked
13. "Private Billing" box will appear

PRIVATE BILLING BOX

The “Private Billing” box is the where the item numbers are entered for the claim.



Private Billing

Patient: 97171.1 Faux, Margaret Balance: 0.00
 Doctor: 634 Oliver (Rochester), Dr Matthew D of B: 12/08/2014

DOS	Code	Description	T	Qt	L	R	Fee	GST
12/08/2014	110	Initial Consultation	P	1	2	W	300.00	0.00
12/08/2014	116	Subsequent Consultation	P	1	2	W	134.00	0.00

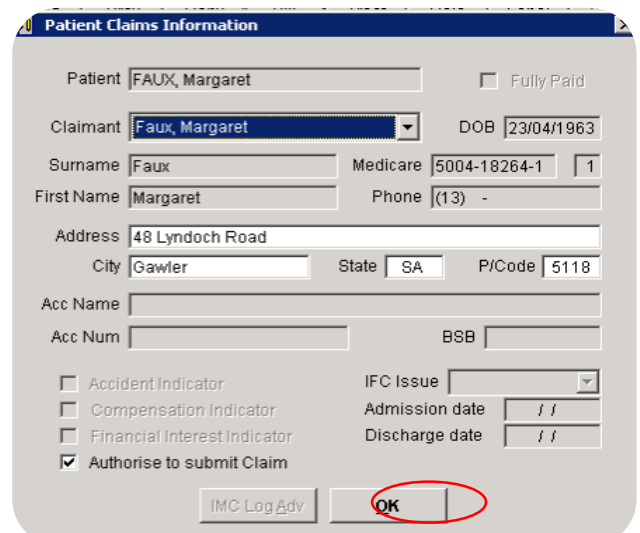
TYPE ITEM NUMBER IN HERE

12/08/2014 [] [] MBSC Dele Edit Quit **Cont** Item 3

14. Check the correct date for the date of service is displayed – Bottom right corner
15. Enter the item number in the correct field next to the date of service field at the bottom left of the screen
16. Select “ENTER”

HINT: Do not continue if the Fee amount shows as zero (\$0) – Refer to your manager

17. Continue to enter the item numbers and select “ENTER” after each item number
18. Once all item numbers have been entered revise and check all of your item numbers and entry in the “Private Billing” box before continuing.
19. Select “Cont” to continue
20. Patient Claims Information box appears
21. Select “OK” (do not need to enter or check anything in this box)



Patient Claims Information

Patient: FAUX, Margaret ☐ Fully Paid

Claimant: FAUX, Margaret DOB: 23/04/1963

Surname: Faux Medicare: 5004-18264-1 1

First Name: Margaret Phone: (13) -

Address: 48 Lyndoch Road

City: Gawler State: SA P/Code: 5118

Acc Name: Acc Num: BSB: IFC Issue: Admission date: Discharge date: / /

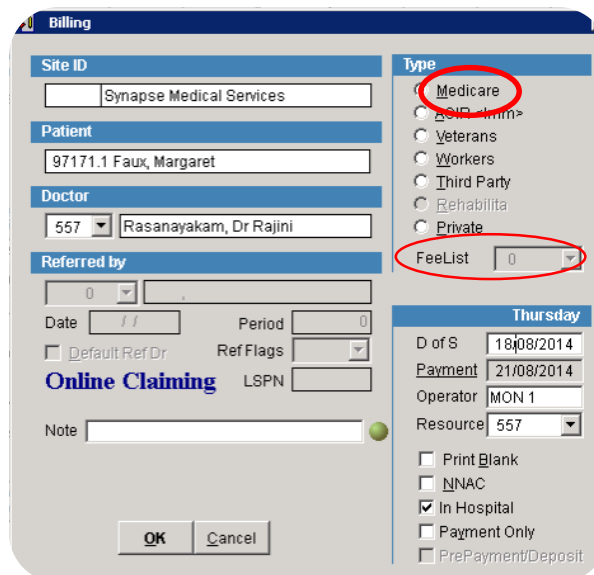
☐ Accident Indicator ☐ Compensation Indicator ☐ Financial Interest Indicator ☒ Authorise to submit Claim

IMC Log Adv **OK**

2. MEDICARE CLAIMS

1. Select the “BILL” function in the patient screen
2. The “Billing” box will appear
3. Check the details on the screen in eclaims with the billing information provided by the doctor.
4. Select “Medicare” for billing “Type”

HINT: Fee list will appear as 0.



The screenshot shows the 'Billing' form with the following details:

- Site ID:** Synapse Medical Services
- Patient:** 97171.1 Faux, Margaret
- Doctor:** 557 Rasanayakam, Dr Rajini
- Referred by:** 0
- Date:** 18/08/2014
- Period:** 0
- Ref Flags:** Default Ref Dr
- Online Claiming:** checked
- Note:** (empty)
- Type:** Medicare (selected)
- FeeList:** 0
- Thursdays:** 18/08/2014
- D of S:** 18/08/2014
- Payment:** 21/08/2014
- Operator:** MON 1
- Resource:** 557
- Checkboxes:**
 - ☐ Print Blank
 - ☐ NNAC
 - ☒ In Hospital
 - ☐ Payment Only
 - ☐ PrePayment/Deposit

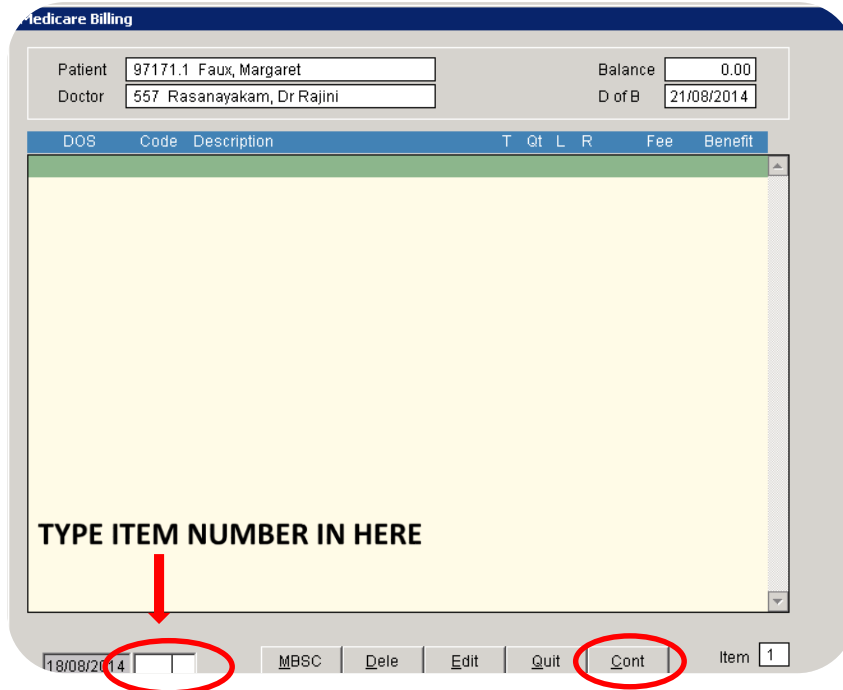
5. Enter Date of Service in “D of S” field.
6. Tick the “In hospital” box for all INPATIENTS
7. Ensure the tick box is NOT selected for “In Hospital” for all OUTPATIENTS
8. Select Hospital if required (refer to section 2.F for instructions)
9. Select referring doctor and referral date in “Referred by” field if required (refer to section 14-15 for instructions)
10. Select OK only once all correct details are entered and checked
11. “Medicare” box will appear

MEDICARE BILLING BOX

The “Medicare Billing” box is where the item numbers are entered for the claim.

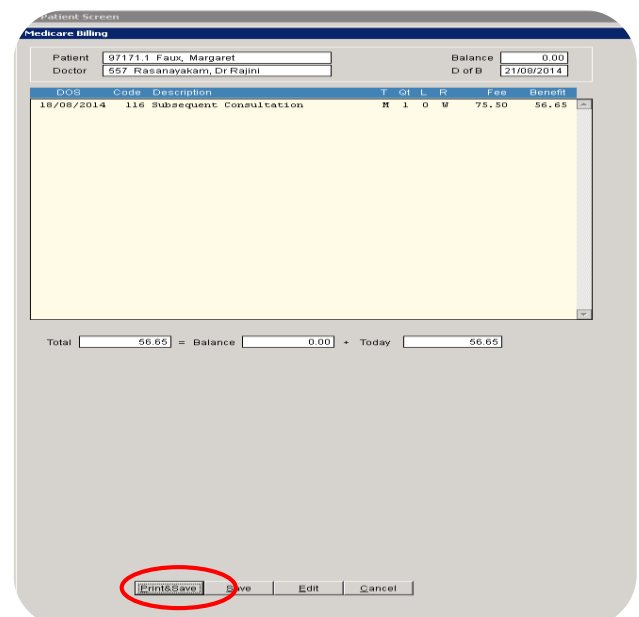
12. Check the correct date for the date of service is displayed – **Bottom right corner**
13. Enter the item number in the correct field next to the ‘DOS’ field at the bottom left of the screen
14. Select “ENTER”

HINT: Do not continue if the Fee amount shows as zero (\$0) – Refer to your manager



The screenshot shows the Medicare Billing interface. At the top, patient and doctor information is displayed: Patient 97171.1 Faux, Margaret; Doctor 557 Rasanayakam, Dr Rajini; Balance 0.00; D of B 21/08/2014. Below this is a table with columns: DOS, Code, Description, T, Qt, L, R, Fee, Benefit. The table is currently empty. A red arrow points to the bottom left of the table area with the text "TYPE ITEM NUMBER IN HERE". At the bottom of the screen, there is a bar with buttons: MBSC, Dele, Edit, Quit, Cont, and Item 1. The "Cont" button is circled in red.

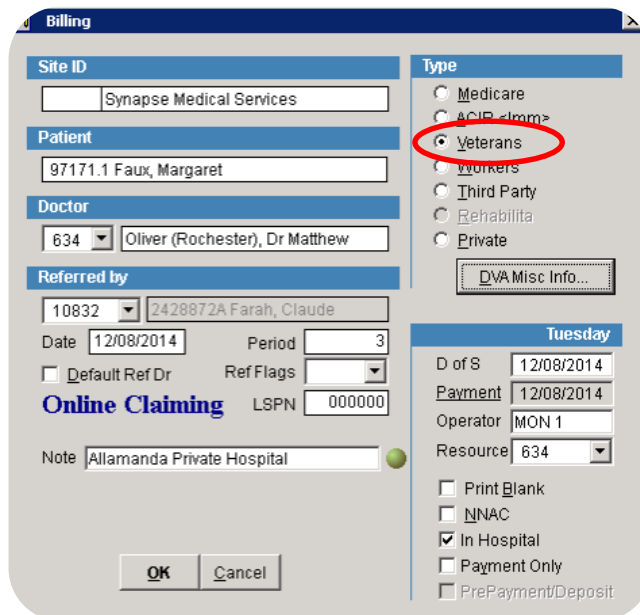
15. Continue to enter the item numbers and select “ENTER” after each item number
16. Once all item numbers have been entered revise and check all of your item numbers and entry in the “Medicare Billing” box before continuing
17. Select “Cont” to continue
18. The printing ‘ Medicare Billing’ screen will appear
19. Click ‘Save’



The screenshot shows the Medicare Billing interface with a completed entry. The table now contains one row: DOS 18/08/2014, Code 116, Description Subsequent Consultation, T M, Qt 1, L 0, R W, Fee 75.50, Benefit 56.65. Below the table, the total is calculated: Total 56.65 = Balance 0.00 + Today 56.65. At the bottom of the screen, there is a bar with buttons: Print&Save, Save, Edit, and Cancel. The "Print&Save" button is circled in red.

3. VETERANS CLAIMS

1. Select the "BILL" function in the patient screen
2. The "Billing" box will appear
3. Check the details on the screen in eclaims with the billing information provided by the doctor.
4. Select "Veterans" for billing "Type"

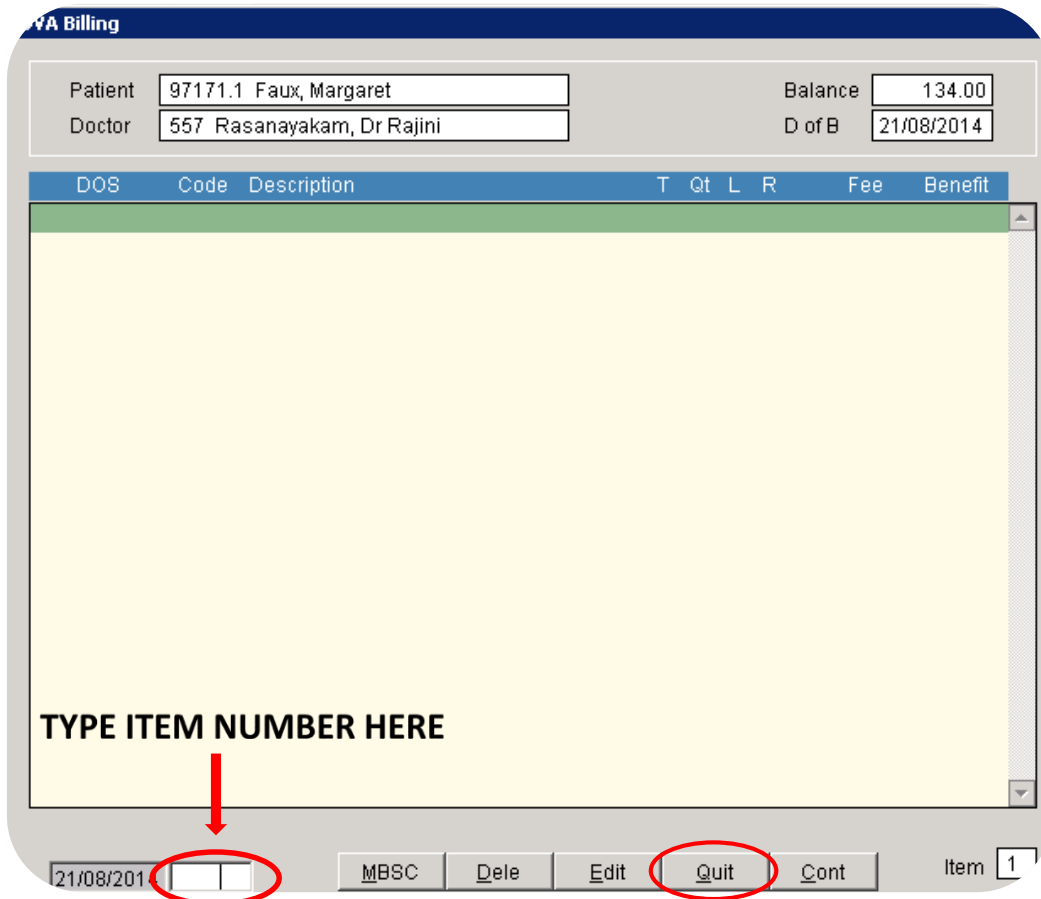


5. Enter Date of Service in "D of S" field.
6. Tick the "In hospital" box for all INPATIENTS
7. Ensure the tick box is NOT selected for "In Hospital" for all OUTPATIENTS
8. Select Hospital if required
9. Select referring doctor and referral date in "Referred by" field if required
10. Select OK only once all correct details are entered and checked
11. "DVA Billing" box will appear

DVA BILLING BOX

The “DVA Billing” box is where the item numbers are entered for the claim.

HINT: Only one date of service “D of S” can be billed at a time/per invoice



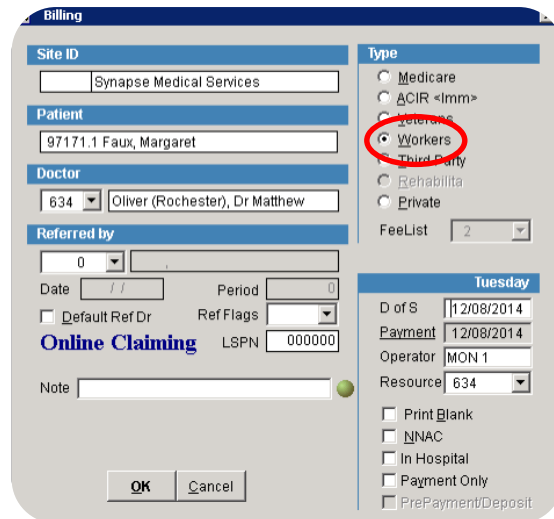
12. Ensure the correct date for the date of service is displayed.
13. Enter the item number in the correct field next to the date of service field at the bottom left of the screen
14. Select “ENTER”

HINT: Do not continue if the Fee amount shows as zero (\$0) – Refer to your manager

15. Continue to enter the item numbers for the date of service and select “ENTER” after each item number
16. Once all item numbers have been entered, revise and check all of your item numbers and entries in the “DVA Billing” box before continuing
17. Select “Cont” to continue

4. WORKERS COMPENSATION CLAIMS

1. Select the “BILL” function in the patient screen
2. The “Billing” box will appear
3. Check details that appear in eclaims with the billing information provided by the doctor
4. Select “WORKERS” for billing “Type”



5. Enter Date of Service in “D of S” filed

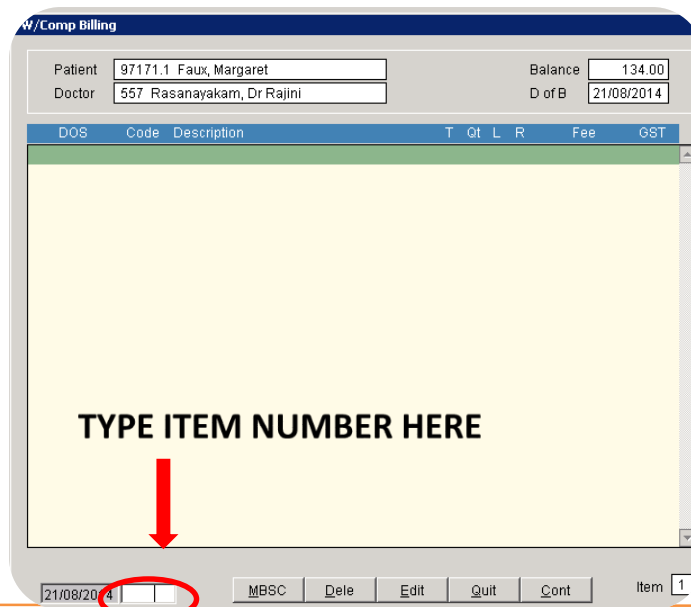
HINT: No referring doctor of hospital details are needed for all workers compensation billing.

6. Select OK only once all correct details are entered and checked
7. W/Comp Billing” box will appear

WORKERS COMPENSATION BILLING BOX

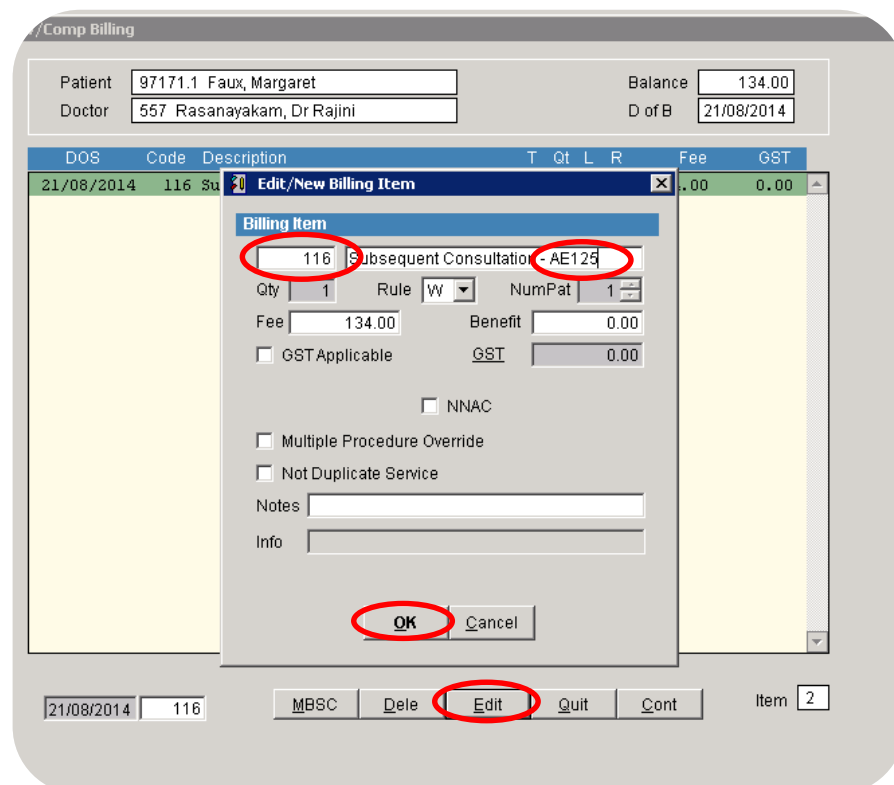
The “W/Comp” box is the where the item numbers are entered for the claim.

NOTE: Only one date of service “D of S” can be billed at a time/per invoice.



8. Ensure the correct date for the date of service is displayed.
9. Enter the item number in the correct field next to the date of service field at the bottom left of the screen
10. Add the AMA code to each item number
 - a. Click on item number
 - b. Select "edit"
 - c. Using the table below add the AMA code next to the item description.
 - d. Select "Ok"
11. Table - AMA codes (Most commonly used codes – for additional codes use the AMA fee schedule)

WORKERS COMPENSATION AMIE CODE
820-AJ051
110-AE115
116-AE125
132-AJ046
133-AJ047
880-AJ200
832-AJ095
830-AJ091
834-AJ101
326-AM095
328-AM105
324-AM085
2801-AF010
2806-AF020
11700-AV100
119-AE125 (Bill at \$75)

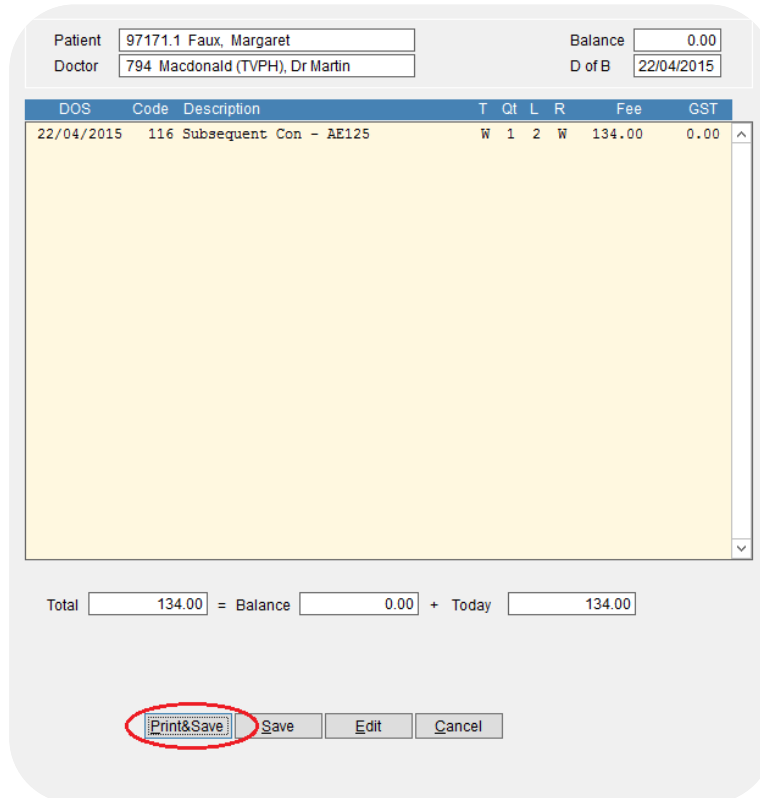


The screenshot shows the 'Comp Billing' window with patient information: 97171.1 Faux, Margaret, Doctor: 557 Rasanayakam, Dr Rajini, Balance: 134.00, D of B: 21/08/2014. The 'Edit/New Billing Item' dialog is open, showing a billing item with DOS 21/08/2014, Code 116, and Description 'Subsequent Consultation'. The AMA code 'AE125' is entered in the 'Code' field. The 'OK' button is circled. The 'Edit' button in the bottom toolbar is also circled.

12. Add the AMA code to each item number billed.
13. Select "CONT"
14. The "W/Comp Billing" box now shows print and save functions

HINT: WHERE THERE IS MORE THAN ONE DOS IN THE BATCH – select save and repeat the billing process again from steps 1-14 again, until all dates of service have been billed & saved.

15. On the final claim select “PRINT & SAVE” instead of save.



Patient: 97171.1 Faux, Margaret
 Doctor: 794 Macdonald (TVPH), Dr Martin
 Balance: 0.00
 D of B: 22/04/2015

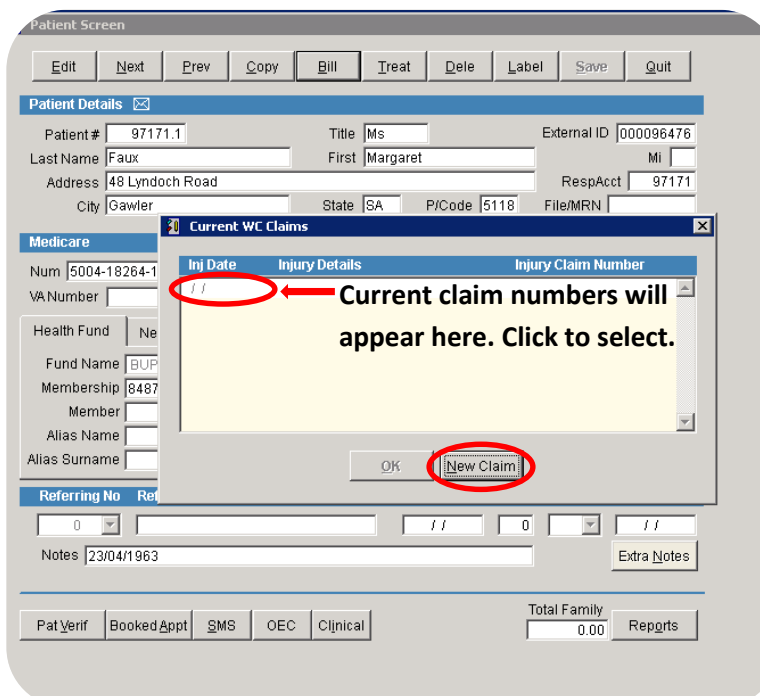
DOS	Code	Description	T	Qt	L	R	Fee	GST
22/04/2015	116	Subsequent Con - AE125	W	1	2	W	134.00	0.00

Total: 134.00 = Balance: 0.00 + Today: 134.00

Print & Save Save Edit Cancel

18. The current W/C claims “claims box” will appear

19. Select the current claim number or create a “new claim”



Patient Screen

Edit Next Prev Copy Bill Treat Dele Label Save Quit

Patient Details

Patient # 97171.1 Title Ms External ID 000096476
 Last Name Faux First Margaret MI
 Address 48 Lyndoch Road RespAcct 97171
 City Gawler State SA P/Code 5118 File/MRN

Medicare

Num 5004-18264-1
 VA Number
 Health Fund Ne
 Fund Name BUP
 Membership 8487
 Member
 Alias Name
 Alias Surname

Current WC Claims

Inj Date Injury Details Injury Claim Number
 Current claim numbers will appear here. Click to select.

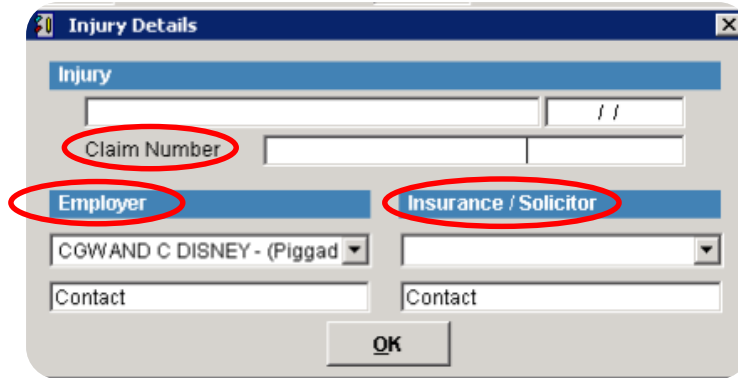
OK **New Claim**

Referring No 0
 Notes 23/04/1963
 Extra Notes

Pat Verif Booked Appt SMS OEC Clinical
 Total Family 0.00 Reports

20. Enter the new claim details

- Enter claim number exactly as provided
- Select either “EMPLOYER” or “INSURANCE/SOLICITOR”
- Optional: Add Contact personal’s First & Last name.



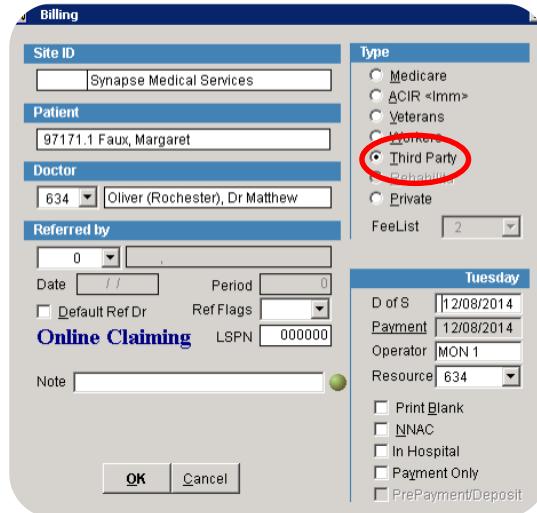
The screenshot shows a window titled "Injury Details". It has a tab labeled "Injury". Below the tab is a text field for "Claim Number" which is circled in red. Below that are two tabs: "Employer" and "Insurance / Solicitor", both of which are circled in red. The "Employer" tab is selected, and its dropdown menu is open, showing "CGWAND C DISNEY - (Piggad)". Below the tabs are two "Contact" text fields. At the bottom is an "OK" button.

21. Once claim number & insurer details are correct. Select OK

22. The claim will now PRINT from your printer.

5. THIRD PARTY COMPENSATION CLAIMS

16. Select the “BILL” function in the patient screen
17. The “Billing” box will appear
18. Check details that appear in eclaims with the billing information provided by the doctor
19. Select “THIRD PARTY” for billing “Type”



20. Enter Date of Service in “D of S” filed

HINT: No referring doctor of hospital details are needed for all third party billing.

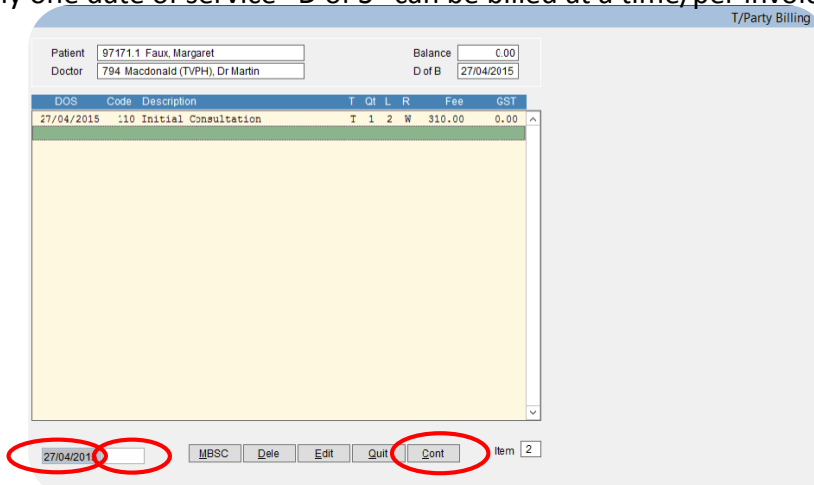
EXCEPTION: All TAC claims need to have referring doctor & referral date. – Add these details as a custom message to the invoice.

21. Select OK only once all correct details are entered and checked
22. Third Party Billing” box will appear

THIRD PARTY BILLING BOX

The “Third Party” box is the where the item numbers are entered for the claim.

HINT: Only one date of service “D of S” can be billed at a time/per invoice



DOS	Code	Description	T	Q	L	R	Fee	GST
27/04/2015	:10	Initial Consultation	T	1	2	W	310.00	0.00

23. Ensure the correct date for the date of service is displayed.

HINT: the grey highlighting around the DOS shows that only one DOS can be entered per invoice.

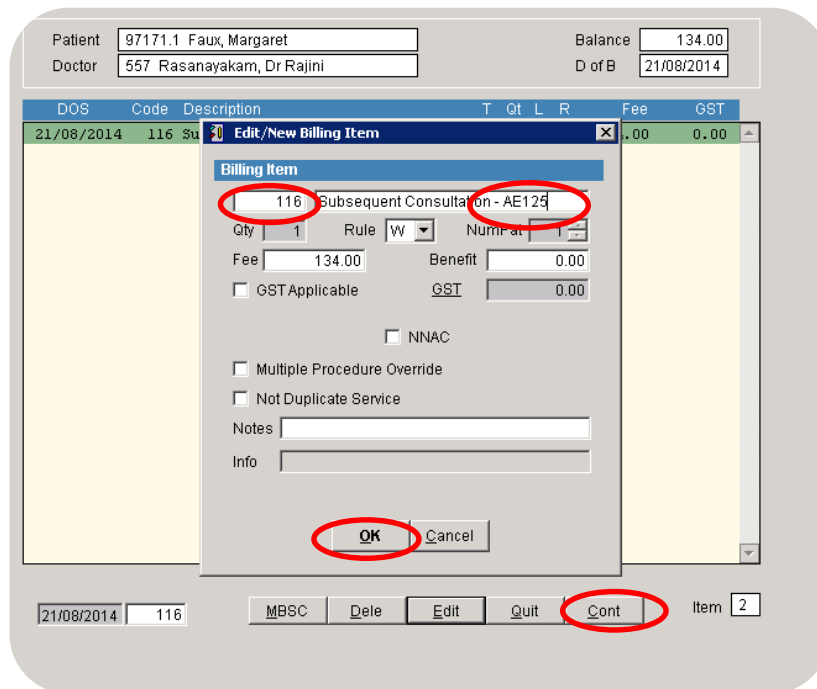
24. Enter the item number in the correct field next to the date of service field at the bottom left of the screen

25. Add the AMA code to each item number

- e. Click on item number
- f. Select “edit”
- g. Using the table below add the AMA code next to the item description.
- h. Select “Ok”

26. Table - AMA codes (Most commonly used codes)

WORKERS COMPENSATION AMA CODE
820-AJ051
110-AE115
116-AE125
132-AJ046
133-AJ047
880-AJ200
832-AJ095
830-AJ091
834-AJ101
326-AM095
328-AM105
324-AM085
2801-AF010
2806-AF020
11700-AV100
119-AE125 (Bill at \$75)



Patient: 97171.1 Faux, Margaret
Doctor: 557 Rasanayakam, Dr Rajini
Balance: 134.00
D of B: 21/08/2014

DOS	Code	Description	T	Qt	L	R	Fee	GST
21/08/2014	116	Subsequent Consultation - AE125					134.00	0.00

Billing Item
 116 Subsequent Consultation - AE125
 Qty: 1 Rule: W NumPat: 1
 Fee: 134.00 Benefit: 0.00
☐ GST Applicable GST: 0.00
☐ NNAC
☐ Multiple Procedure Override
☐ Not Duplicate Service
 Notes:
 Info:

OK **Cancel**

21/08/2014 116 MBSC Dele Edit Quit **Cont** Item 2

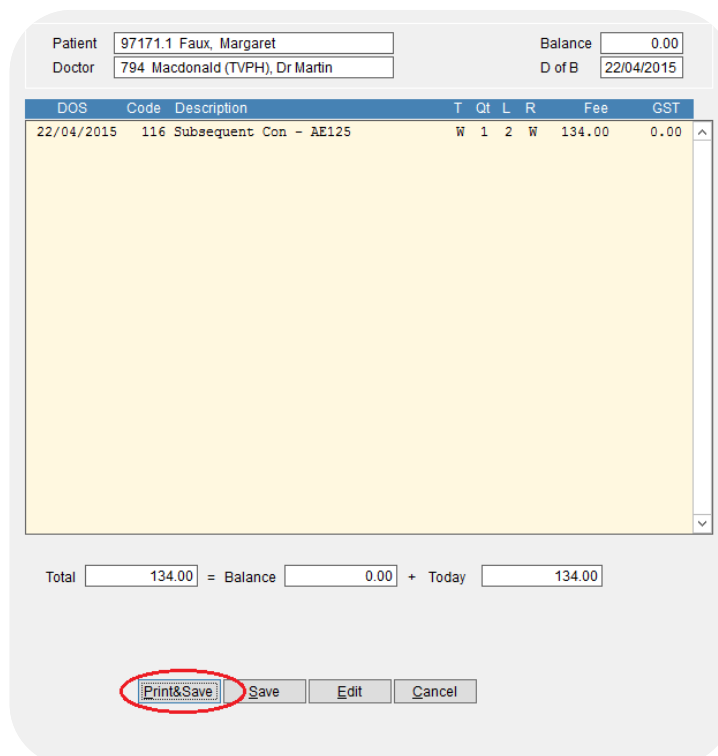
27. Add the AMA code to each item number billed.

28. Select "CONT"

29. The "Third Party Billing" box now shows print and save functions

HINT: WHERE THERE IS MORE THAN ONE DOS IN THE BATCH – select save and repeat the billing process again from steps 1-14 again, until all dates of service have been billed & saved.

30. On the final claim select "PRINT & SAVE" instead of save. Then Continue



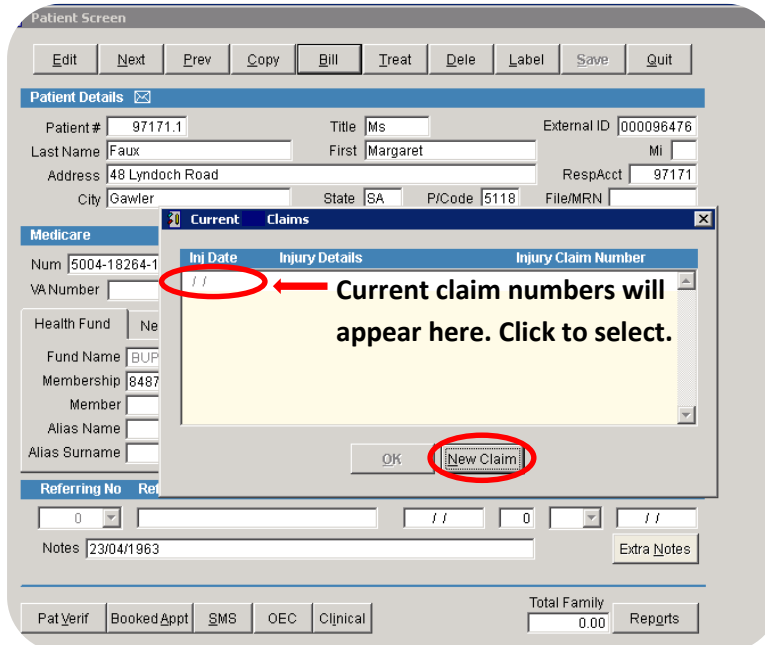
Patient: 97171.1 Faux, Margaret
Doctor: 794 Macdonald (TVPH), Dr Martin
Balance: 0.00
D of B: 22/04/2015

DOS	Code	Description	T	Qt	L	R	Fee	GST
22/04/2015	116	Subsequent Con - AE125	W	1	2	W	134.00	0.00

Total: 134.00 = Balance: 0.00 + Today: 134.00

Print&Save **Save** **Edit** **Cancel**

31. The current Third Party “claims box” will appear
32. Select the current claim number or create a “new claim”

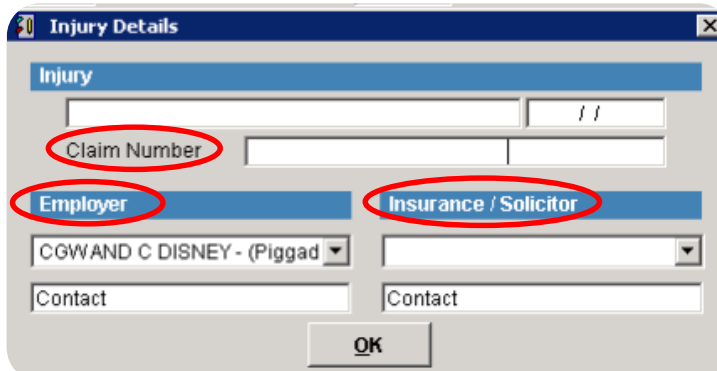


Current Claims

Inj Date	Injury Details	Injury Claim Number
		///

OK **New Claim**

33. Enter the new claim details
 - a. Enter claim number exactly as provided
 - b. Select either “EMPLOYER” or “INSURANCE/SOLICITOR”
 - c. Optional: If known add contact personal’s first & last name.



Injury Details

Injury

Claim Number

Employer

Insurance / Solicitor

CGWAND C DISNEY - (Piggad)

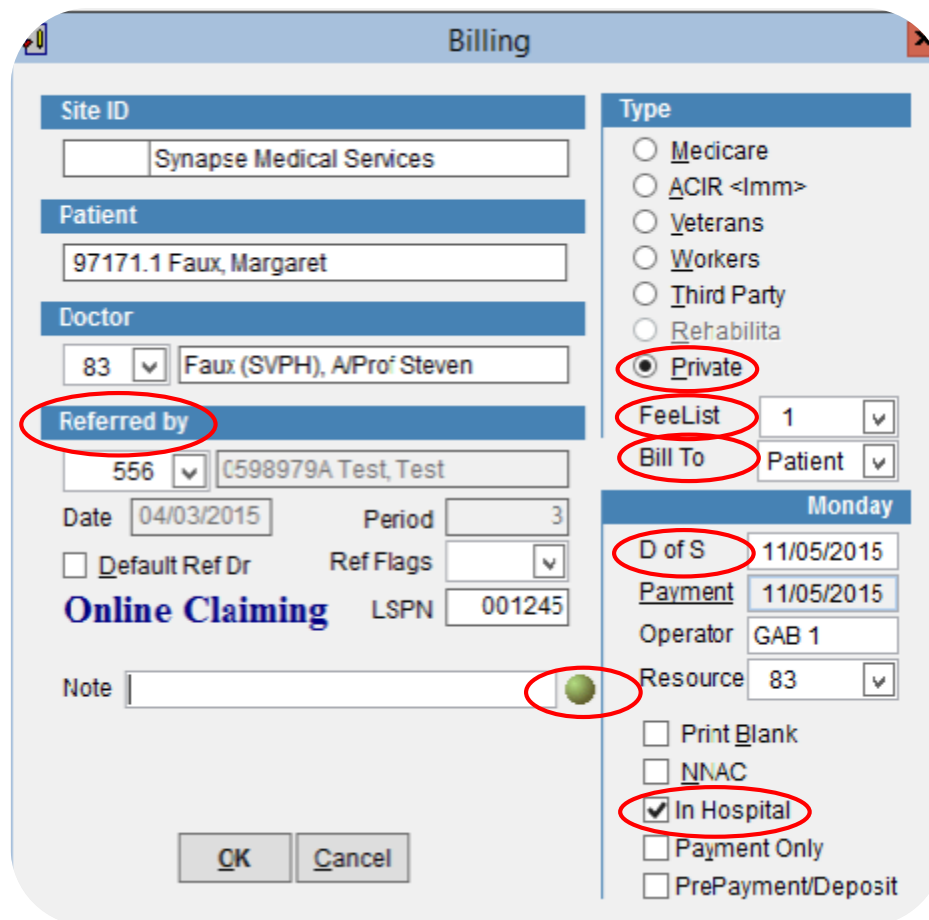
Contact

OK

34. Once claim number & insurer details are correct. Select OK
35. The claim will now PRINT from your printer.

4. PRIVATE BILLING TO THE PATIENT

1. Select the “BILL” function button in the patient screen
2. The “Billing” box will appear.
3. Check details that appear in eclaims with the billing information provided by the doctor



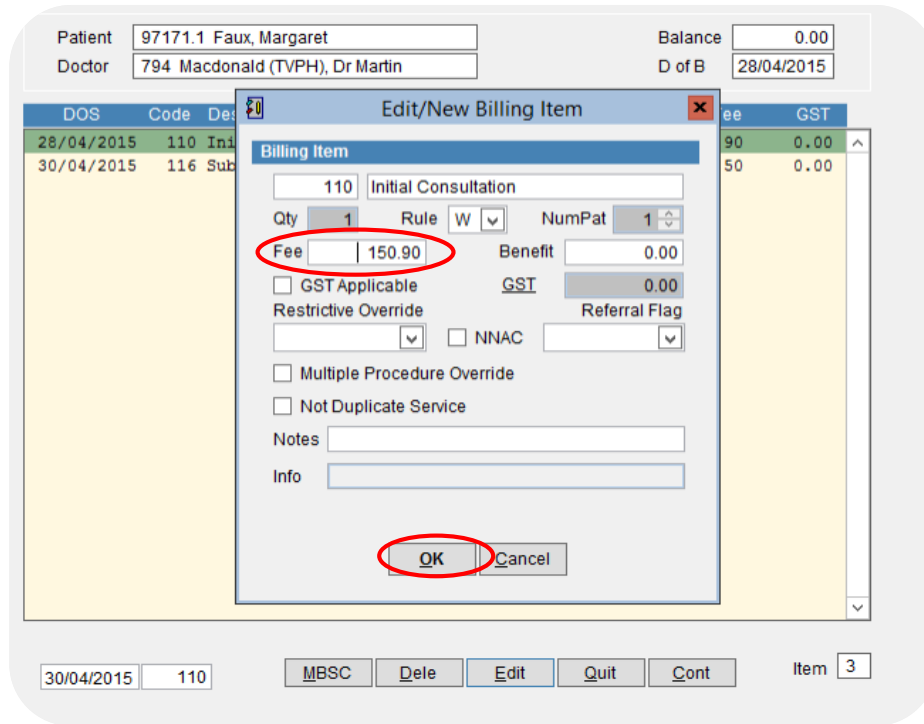
4. Select “Private” for billing “Type”
5. Select Feelist as number 1 – Unless otherwise advised.

HINT: Billing as Fee 1 allows you to edit and change the amount billed for each item number. Only bill using another Fee number if your supervisor has advised you to do so in order to compete a different type of private billing to the patient.

6. Select “Bill To” field as “Patient”
7. Enter Date of Service in “D of S” filed
8. Select “In hospital” for all INPATIENTS

16. Click on the item number you which to edit.

17. Select “Edit”



18. Enter the new FEE AMOUNT in the “Fee” field – *see circled selection in figure above*

19. Select Ok.

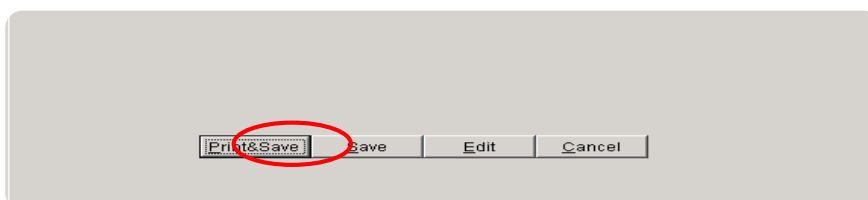
20. Continue to enter the item numbers and edit the fee amounts until all item numbers have been entered correctly.

21. Once all item numbers have been entered, revise and check all of your item numbers and entry in the “Private Billing” box before continuing

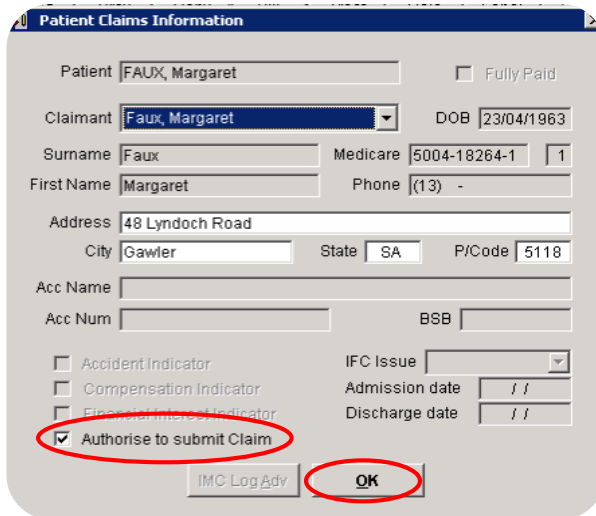
22. Select “Cont” to continue

HINT: Patient claims need to be sent manually to the recipient.

23. Click “Print & Save” to print the claim for mailing - *unless otherwise advised by a supervisor*



24. The “Patient Claims Information” box will now appear.



25. **IMPORTANT:** REMOVE the tick “authorising the claim to be submitted” – *As circled above*

26. Click OK to complete the patient claim process

27. Collect printed invoices from your printing device.

5. **KNOWN GAP BILLING**

Known gap agreement means an agreement where the medical practitioner agrees to accept a payment by the insurer in part satisfaction of the amount owed and the patient has provided informed financial consent so that the gap or out of pocket expense to be paid by the insured person is known in advance.

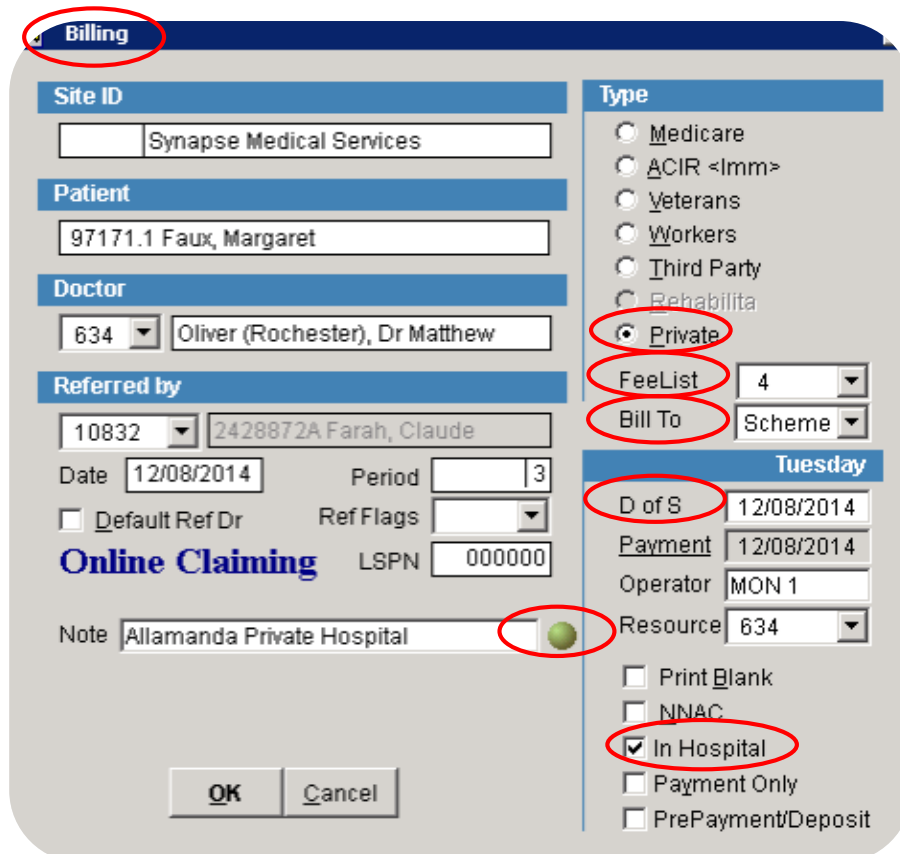
Known gap claiming is billed using two of the above explained billing methods.

1. **PART 1 – NO GAP BILLING** - Claim is sent to the Health fund with added note to explain how much the patient has been charged as a known gap. –
2. **PART 2 – PRIVATE PATIENT CLAIM** - The claim is billed to the patient. This claim is the remaining amount (GAP) after the health fund & Medicare have paid their contributions. The billing is sent to the patient with notification of the item numbers claimed and amount charged to their health fund.

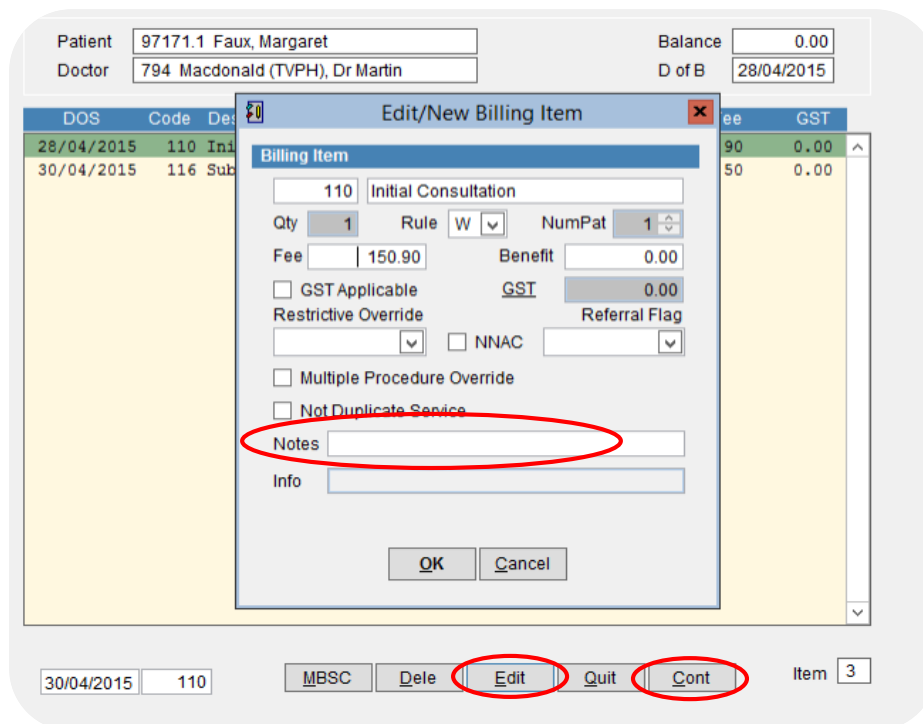
KNOWN GAP BILLING – PART 1

INVOICE THE HEALTH FUND – *Instructions match NO GAP billing instructions given on page 15*

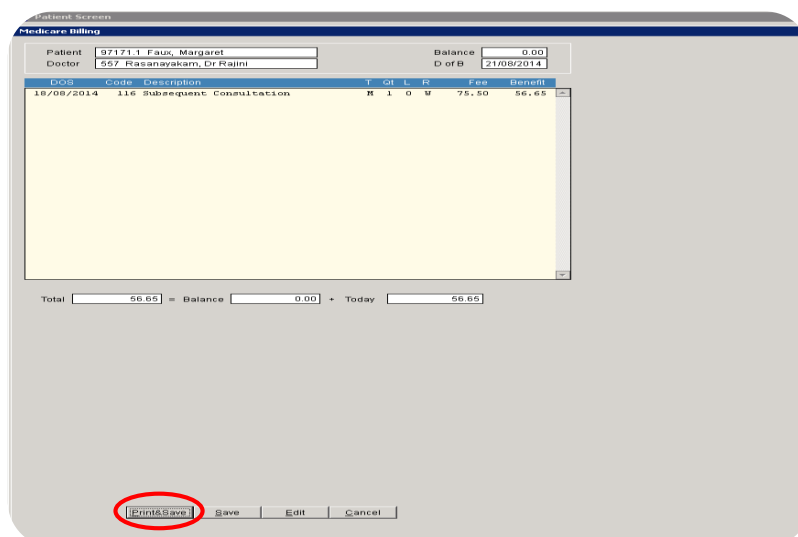
1. Select the “BILL” function button in the patient screen
2. The “Billing” box will appear.
3. Check details that appear in eclaims with the billing information provided by the doctor



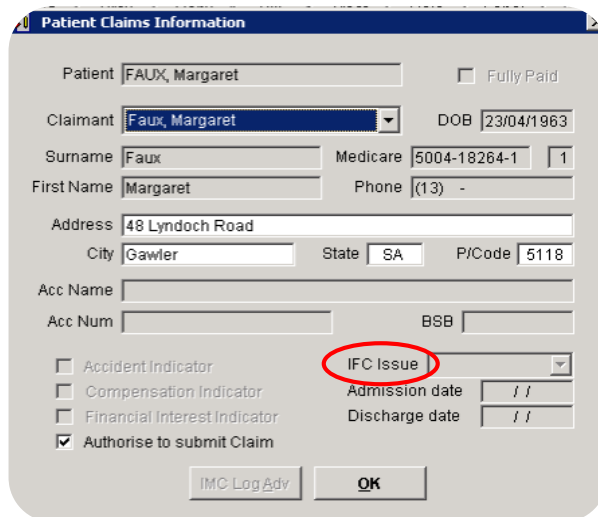
4. Select “Private” for billing “Type”
5. Check correct FeeList appears
6. Check correct “Bill To” field appears and if not change it to correct fee
7. Enter Date of Service in “D of S” field
8. Select “In hospital” for all INPATIENTS
9. Ensure the tick box is NOT selected for “In Hospital” for all OUTPATIENTS
10. Select Hospital if required
11. Select referring doctor and referral date in “Referred by” field if required
12. Select OK only once all correct details are entered and checked
13. “Private Billing” box will appear



19. Revise and check all of your item numbers and entry in the "Private Billing" box before continuing
20. Select "Cont" to continue
21. Select PRINT & SAVE, the claim will be transmitted electronically however you will need the invoice to know the amounts the health fund has been billed during billing of Part 2 -the patient claim



22. Patient Claims Information box appears



Patient Claims Information

Patient: FAUX, Margaret ☐ Fully Paid

Claimant: Faux, Margaret (dropdown) DOB: 23/04/1963

Surname: Faux Medicare: 5004-18264-1 1

First Name: Margaret Phone: (13) -

Address: 48 Lyndoch Road

City: Gawler State: SA P/Code: 5118

Acc Name:

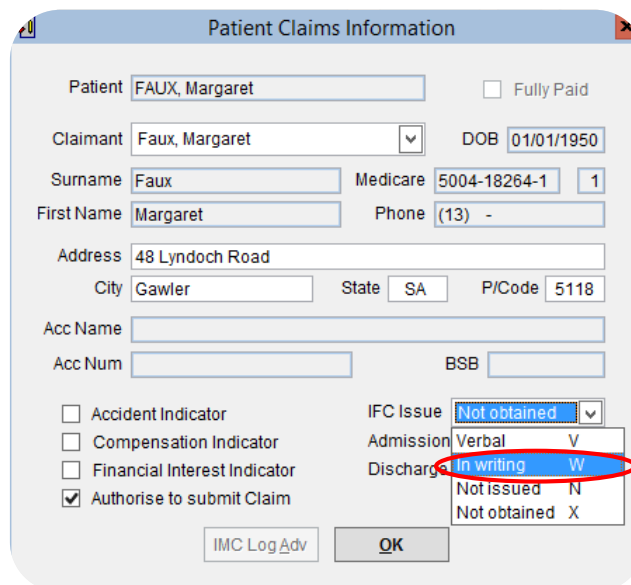
Acc Num: BSB:

☐ Accident Indicator ☐ Compensation Indicator ☐ Financial Interest Indicator ☒ Authorise to submit Claim

IFC Issue: (dropdown menu) Admission date: / / Discharge date: / /

IMC Log Adv OK

23. Click the drop down box to select the “IFC Issue” method



Patient Claims Information

Patient: FAUX, Margaret ☐ Fully Paid

Claimant: Faux, Margaret (dropdown) DOB: 01/01/1950

Surname: Faux Medicare: 5004-18264-1 1

First Name: Margaret Phone: (13) -

Address: 48 Lyndoch Road

City: Gawler State: SA P/Code: 5118

Acc Name:

Acc Num: BSB:

☐ Accident Indicator ☐ Compensation Indicator ☐ Financial Interest Indicator ☒ Authorise to submit Claim

IFC Issue: Not obtained (dropdown menu) Admission: Verbal V Discharge: In writing W Not issued N Not obtained X

IMC Log Adv OK

24. Select IFC ISSUED: “In Writing” from the drop menu

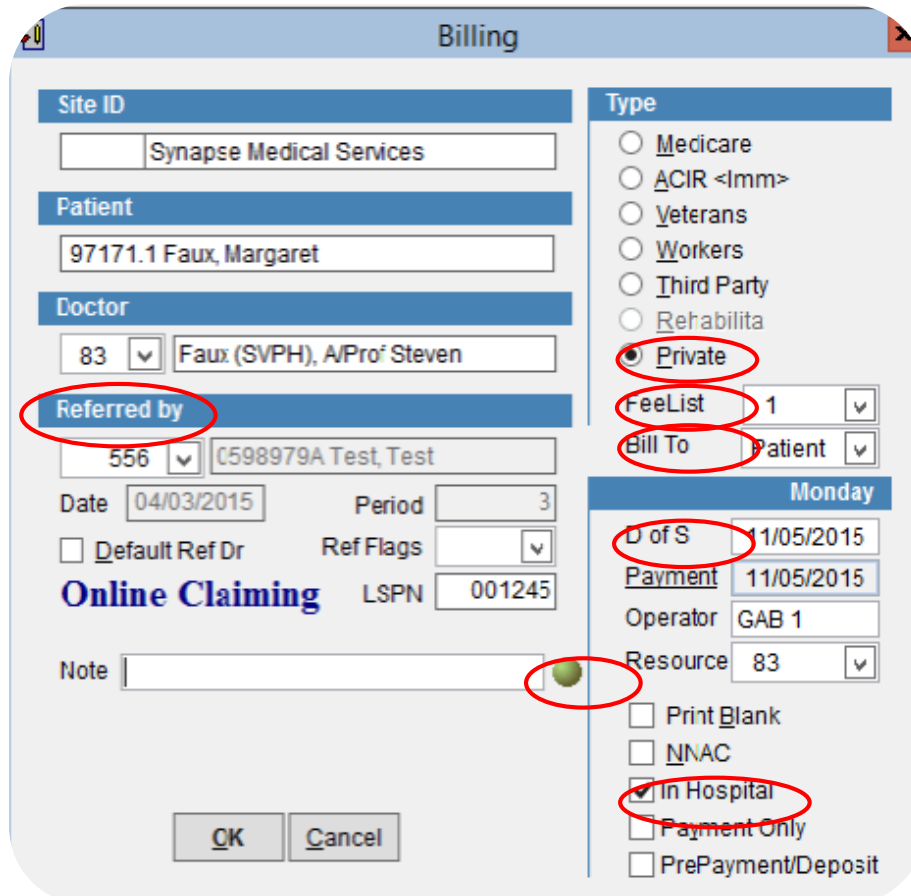
25. Select “OK”

26. Continue with part 2 of the Known Gap claim

KNOWN GAP BILLING – PART 2

INVOICE TO THE PATIENT

1. Select the “BILL” function button in the patient screen
2. The “Billing” box will appear.
3. Check details that appear in eclaims with the billing information provided by the doctor



4. Select “Private” for billing “Type”
5. Select Feelist as number 1 – Unless otherwise advised.

HINT: Billing as Fee 1 allows you to edit and change the amount billed for each item number. Only bill using another Fee number if your supervisor has advised you to do so in order to compete a different type of private billing to the patient

6. Select “Bill To” field as “Patient”
7. Enter Date of Service in “D of S” field
8. Select “In hospital” for all INPATIENTS

9. Ensure the tick box is NOT selected for “In Hospital” for all OUTPATIENTS
10. Select Hospital if required
11. Select referring doctor and referral date in “Referred by” field if required (outlined in steps 14-15)
12. Select OK only once all correct details are entered and checked
13. “Private Billing” box will appear

PRIVATE BILLING BOX

The “Private Billing” box is the where the item numbers are entered for the claim.

Private Billing

Patient97171.1 Faux, MargaretBalance0.00Doctor634 Oliver (Rochester), Dr MatthewD of B12/08/2014

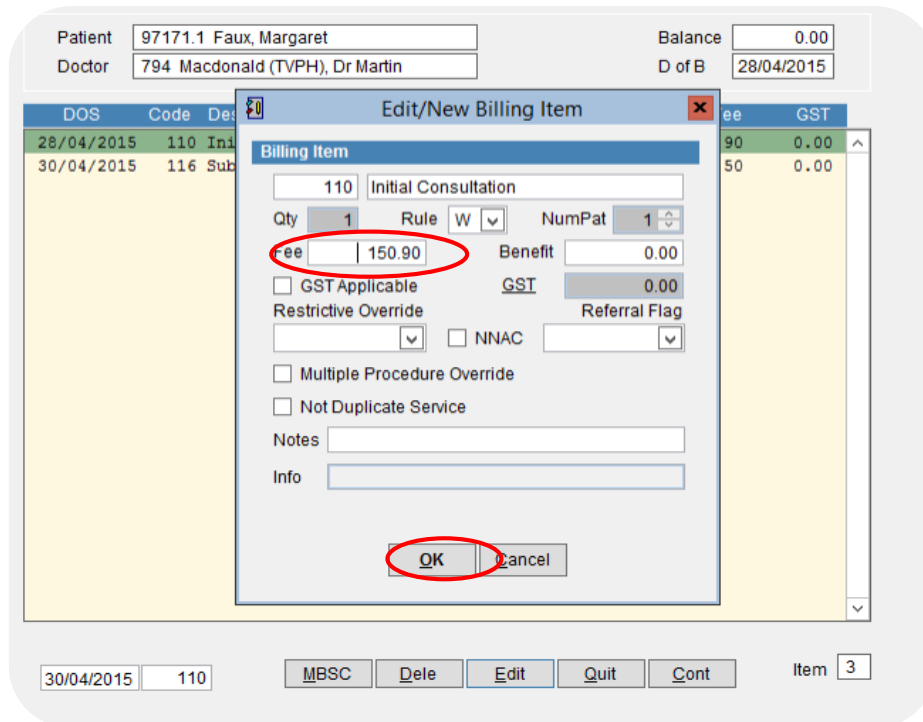
DOS	Code	Description	T	Qt	L	R	Fee	GST
12/08/2014	110	Initial Consultation	P	1	2	W	300.00	0.00
12/08/2014	116	Subsequent Consultation	P	1	2	W	134.00	0.00

TYPE ITEM NUMBER IN HERE

12/08/2014MBSCDeleEditQuitContItem3

14. Check the correct date for the date of service is displayed – **Bottom right corner**
15. Enter the KNOWN GAP (KG) billing amount:
 - a. Enter the letters KG into the item number field
 - b. The pop up box will appear
 - c. Set the fee as the gap amount that you need to charge the patient – *If you are unsure of this amount check with your supervisor*
 - d. Select ok. Continue to follow the below steps
16. After the KG Item has been entered, continue to enter all of the item numbers used during the service as per the doctors billing instructions.

17. Once all item numbers have been entered, you will need to adjust the amounts of all item numbers (except the KG item) to show the exact fee's charged to the health fund – *follow the steps below*
18. Click on the item number you which to edit.
19. Select “Edit”
20. The “Edit/New Billing Item” box will appear

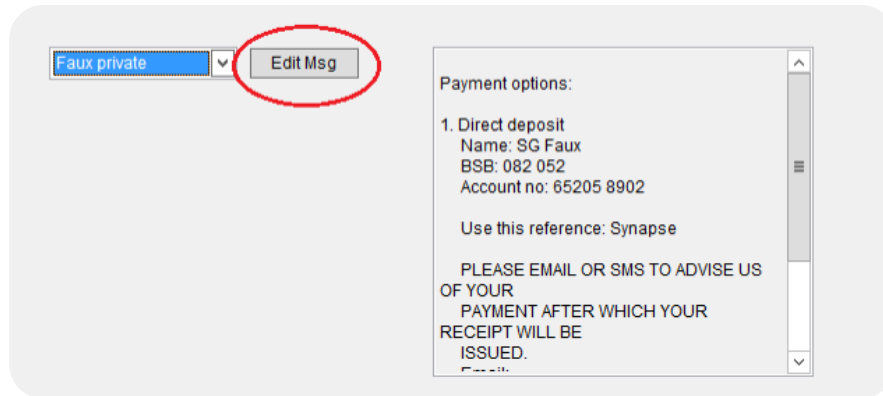


28. Using the bill invoice that you printed at the end of Part 1 (Bill to the Health Fund). Enter the specific amounts that the health fund has paid for each individual item number.
29. Enter the new FEE AMOUNT in the “Fee” field – *see circled selection in figure above*
30. Select Ok.
31. Continue to enter the item numbers and edit the fee amounts until all item numbers have been entered correctly.
32. Once all item number have been entered, check that the automatic invoice message has appeared at the bottom of the page

HINT: Invoice messages will appear automatically, the message outlines payment details for the doctor. If no invoice message appears please inform your supervisor.

33. If the invoice message has appeared at the bottom of the page you will now need to edit this message to add a custom note to your Known Gap private claim – *follow instructions below*

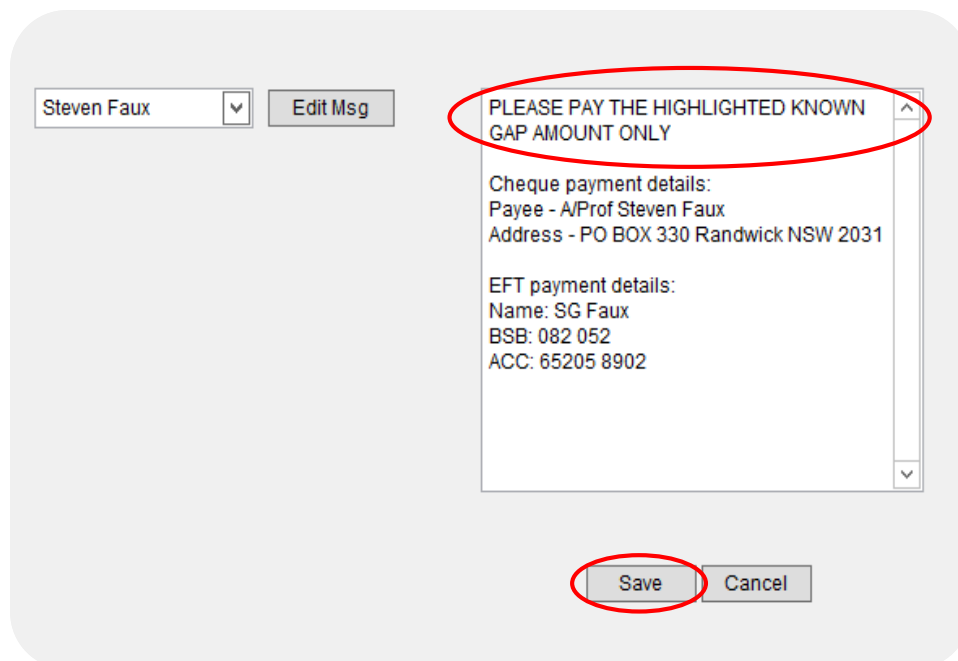
- a. Click on the “Edit Msg” button at the bottom on the screen – The message box will now turn white and allow you to type new text in the box



The screenshot shows a user interface with a dropdown menu set to 'Faux private' and an 'Edit Msg' button circled in red. To the right, a text area contains the following text:

Payment options:
 1. Direct deposit
 Name: SG Faux
 BSB: 082 052
 Account no: 65205 8902
 Use this reference: Synapse
 PLEASE EMAIL OR SMS TO ADVISE US
 OF YOUR
 PAYMENT AFTER WHICH YOUR
 RECEIPT WILL BE
 ISSUED.

- b. Click above all other text in the message box
- c. In capital letters, enter the sentence “PLEASE PAY THE HIGHLIGHTED KNOWN GAP AMOUNT ONLY”



The screenshot shows the same user interface as before, but now the dropdown menu is set to 'Steven Faux' and the 'Edit Msg' button is no longer circled. The text area now contains the following text:

PLEASE PAY THE HIGHLIGHTED KNOWN
 GAP AMOUNT ONLY

Below the text area, the 'Save' button is circled in red, and the 'Cancel' button is visible next to it.

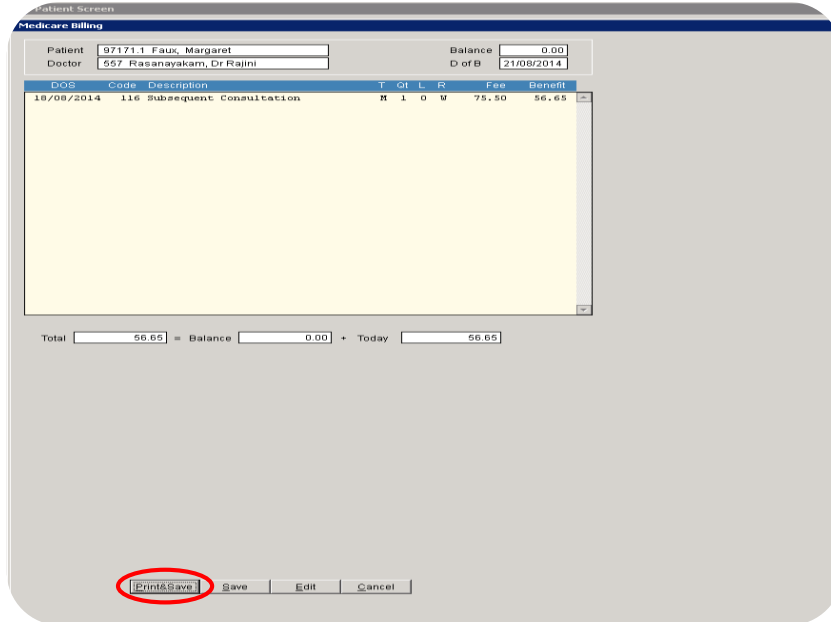
- d. Read through your added message to ensure there are no spelling mistakes
- e. Click SAVE – the message box will now turn grey again

34. Once all pf the above steps have been completed, revise and check all of your work and entry in to the “Private Billing” box before continuing

35. Select “Cont” to continue

HINT: Patient claims need to be sent manually to the recipient

36. Click “Print & Save” to print the claim for mailing - *unless otherwise advised by a supervisor*



Medicare Billing

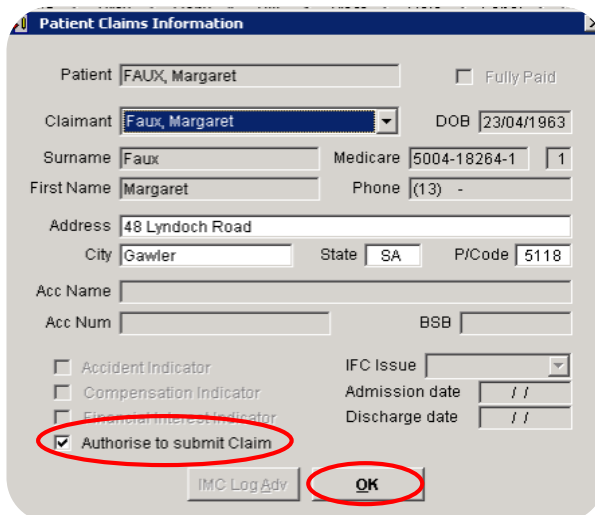
Patient: 97171.1 Faux, Margaret
 Doctor: 657 Rasanayagam, Dr Rajini
 Balance: 0.00
 D of B: 21/08/2014

DOS	Code	Description	T	Q	L	R	Fee	Benefit
10/08/2014	116	Subsequent Consultation	M	1	0	W	75.50	56.65

Total: 56.65 = Balance: 0.00 + Today: 56.65

Print & Save Save Edit Cancel

37. The “Patient Claims Information” box will now appear.



Patient Claims Information

Patient: FAUX, Margaret ☐ Fully Paid

Claimant: Faux, Margaret DOB: 23/04/1963

Surname: Faux Medicare: 5004-18264-1 1

First Name: Margaret Phone: (13) -

Address: 48 Lyndoch Road

City: Gawler State: SA P/Code: 5118

Acc Name:
 Acc Num:
 BSB:
☐ Accident Indicator IFC Issue:
☐ Compensation Indicator Admission date: / /
☐ Financial Interest Indicator Discharge date: / /
☒ Authorise to submit Claim

IMC Log Adv **OK**

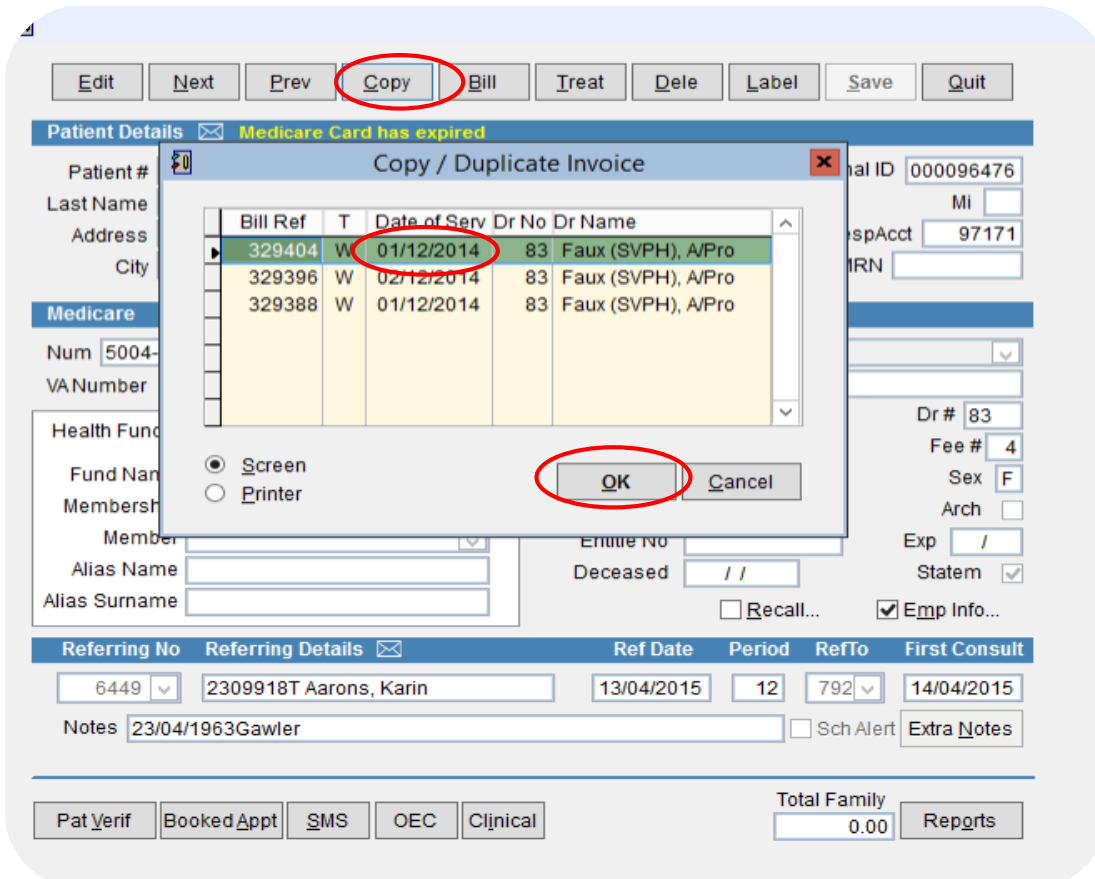
38. **IMPORTANT:** REMOVE the tick “authorising the claim to be submitted” – *As circled above*

39. Click OK to complete the patient claim process

40. Collect printed invoices from your printing device.

6. REVIEWING THE COMPLETED INVOICE FOR ACCURACY/ RE-PRINTING A CLAIM

After completing a batch of billing you MUST always open a copy of the invoice you have billed and check over it again for any mistakes that may have been missed previously.



The screenshot shows the 'Copy / Duplicate Invoice' dialog box. The table of invoices is as follows:

Bill Ref	T	Date of Serv	Dr No	Dr Name
329404	W	01/12/2014	83	Faux (SVPH), A/Pro
329396	W	02/12/2014	83	Faux (SVPH), A/Pro
329388	W	01/12/2014	83	Faux (SVPH), A/Pro

The 'OK' button is circled in red. The background shows patient details and a 'Medicare Card has expired' warning.

1. Click on the COPY button at the top of the patient screen
2. All invoices billed to the patient will appear in the "Copy/Duplicate Invoice Box"
3. The invoices are displayed with the most recently billed invoice at the top of the list
4. Select the way you would like to view the invoice: Screen or Printer
5. Click Ok
6. Your invoice will now appear either on the screen or in your printer

HINT: If the invoice reads as a "LODGEMENT ADVICE" then an error has been made and you will need to delete this invoice and re-bill the claim – Unless a supervisor has instructed you to lodge this patient's claim.

MEDICAL BILLING MANUAL – COMPLEX CLAIMING

1. SURGICAL CLAIMING – APPLYING THE MULTIPLE SERVICE RULE

The multiple service rule (MSR) refers to multiple procedures performed at the same session by the same provider. The multiple service rule only applies to claims for the surgical provider or surgical assistant, the MSR does not apply to Anaesthetists.

The Rule:

- 100% of the allowed amount is claimable by the provider for the highest paying item number
- 50% of the allowed amount is claimable for the second highest paying item number
- 25% of the allowed amount is claimable for any existing surgical procedure item numbers

HINT: Medicare procedure items usually begin with the number 3 or 4

IMPORTANT: PLEASE USE PREVIOUS INSTRUCTIONS ON HOW TO BILL EACH SPECIFIC BILLING TYPE BELOW – APPLY THE MSR TO THE ITEM NUMBERS DURING THE BILLING PROCESS

Applying to multiple service rule to billing types:

1. No gap, Medicare and Veterans Claiming:

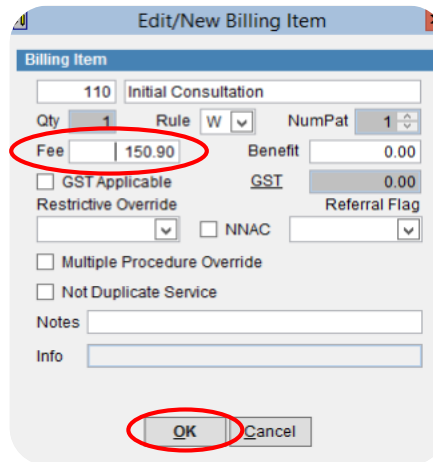
The MSR will be applied automatically after all item numbers have been entered and you have clicked continue.

2. Workers' Compensation, Third Party, Patient Claiming:

The MSR will need to be applied during the billing process

1. Enter all of the item numbers claimed into the patient screen billing box
2. Look at the prices assigned to each surgical item and apply the formula
 - 100% for the highest paying surgical item
 - 50% for the second highest paying surgical item
 - 25% for all respective surgical items
3. Calculate the new amounts for each item on a piece of scrap paper

4. Using the edit process – Apply the new prices to the item numbers
 - a. Click on the item number you which to edit.
 - b. Select “Edit”



The screenshot shows a dialog box titled "Edit/New Billing Item". Inside, there's a "Billing Item" section with a text box containing "110" and "Initial Consultation". Below this are fields for "Qty" (1), "Rule" (W), and "NumPat" (1). The "Fee" field is highlighted with a red circle and contains the value "150.90". To the right of the "Fee" field is a "Benefit" field with the value "0.00". Below these are several checkboxes: "GST Applicable", "Restrictive Override", "Multiple Procedure Override", and "Not Duplicate Service". There are also dropdown menus for "Referral Flag" and "NNAC". At the bottom, there are "Notes" and "Info" text boxes. The "OK" button is circled in red.

- c. Enter the new FEE AMOUNT in the “Fee” field – *see circled selection in figure above*
- d. Select Ok.
- e. Continue to enter the item numbers and edit the fee amounts until all item numbers have been entered correctly.
- f. Once all item numbers have been entered, revise and check all of your item numbers and entry in the “Private Billing” box before continuing

3. Known gap

The Multiple Service Rule is applied to both the Health Fund & the Patient billing portion of the surgical procedure.

1. Part 1 – Claim to the Health Fund

This method of billing will automatically apply to multiple service rule

2. Part 2 – Claim to the Patient

The MSR will need to be applied directly to the patient billing as shown above.

Please refer to your printed invoice of the Health Fund claim (Part 1) for the revised surgical prices for each item number.